THE IMPACT OF A SIX-MONTH PROFESSSONAL DEVELOPMENT PROGRAM ON ELEMENTARY TEACHERS' KNOWLEDGE AND SELF-EFFICACY FOR RECOGNIZING AND RESPONDING TO STUDENT MENTAL HEALTH SYMPTOMS

by
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Abstract

This dissertation study examines teacher knowledge and self-efficacy when working with elementary students with mental health disorders. Specifically, the study investigates how a teacher professional development influences teachers' knowledge and self-efficacy when working with students with mental health disorders. The distal outcome of the study is to increase success of the school reintegration process for elementary students returning to school following psychiatric hospitalization. Chapter one presents a review of current literature which explores the interplay of several child, family, teacher, economic, and cultural factors which affect the school reintegration process. Based on the literature, the convergent parallel mixed methods needs assessment specifically examined teacher factors, specifically how beliefs and attitudes, self-efficacy, and professional learning influence the manner in which teachers respond to elementary aged students with mental health disorders. Key findings revealed that many elementary teachers lacked professional development or training in supporting student mental health. Likewise, teachers had limited knowledge in mental health disorder symptoms and low self-efficacy in recognizing and responding to student needs, especially externalized behaviors. These results informed the plan of a six-month professional development program focusing on childhood mental health disorders and classroom behavior strategies. The goal of the intervention was to increase elementary teachers' knowledge of mental health disorders, as well as increase teachers' self-efficacy in working with students with mental health disorders. The researcher conducted a pretest-posttest convergent parallel mixed methods study to evaluate the intervention program. The results provide evidence that knowledge and self-efficacy increases for recognizing and responding to student mental health symptoms. Study findings suggest that the program is effective in meeting the short-term outcome of improving teachers' knowledge

and self-efficacy lending itself to increasing the distal goal of increasing the successfulness of the reintegration process.

Keywords: student mental health, mental health symptoms, classroom behavior strategies, professional development

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Dedication

This dissertation is dedicated to elementary students with mental health disorders who navigate classroom settings each day. Additionally, this dissertation is dedicated to elementary teachers and school systems who strive to learn about mental health disorders in an effort to support students.

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Executive Summary

Elementary age children diagnosed with mental health disorders, including anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD) may present symptoms in the classroom setting (Clemens et al., 2011). An increasing number of children exhibiting acute symptoms receive inpatient psychiatric care for symptom stabilization (Chun et al., 2016), but return to school shortly after discharge (Clemens et al., 2011). Teachers are often considered front-line adults who are in positions to recognize mental health symptoms, make appropriate referrals, and support children when returning to school after hospitalization (Rothi et al., 2008). However, teachers report having limited knowledge or self-efficacy in working with students with mental health disorders. This study examines a professional development intervention aimed at increasing teachers' knowledge and self-efficacy in working with children with mental health disorders and symptoms, with the long-term goal of increasing the successfulness of elementary students' reintegration into the school environment after psychiatric hospitalization.

Problem of Practice

Approximately 15% of children in the United States are diagnosed with mental, developmental, and behavioral disorders (Bitsko et al., 2016). According to current research, a growing number of children with mental health disorders require psychiatric hospitalization (Chun et al., 2016; Grupp-Phelan et al., 2017). Shortly after discharge, however, children are required to return to school (Savina et al., 2014). While schools are becoming increasingly aware of student mental health needs, teachers and other school staff often have limited experience in recognizing and responding to students' mental health needs. Elementary teachers have limited training and professional development in mental health disorders (Reinke et al., 2011). With limited professional development, elementary teachers lack knowledge and self-efficacy in

recognizing and responding to students' mental health symptoms (Alisic, 2012; Reinke et al., 2011; Rothi et al., 2008). As such, schools are ill-prepared to recognize and respond to mental health needs.

Background and Context

Addressing the problem of student barriers to students' reintegration following psychiatric hospitalization occurred in Lake Public Schools (LPS; a pseudonym), a suburban Midwestern public school district. While many research studies on student mental health and school reintegration focus on adolescent and secondary teachers' experiences, the current study involved students and teachers at the elementary level. The district currently employs elementary teachers in seven schools across the district.

Theoretical Framework

The theoretical framework guiding the literature review was Bronfenbrenner's (1979) ecological systems theory (EST). The framework suggests that child development takes places because of interactions within multiple systems and contexts. Specifically, microsystem, mesosystem, and macrosystem interactions influence development through direct interaction with the child, such a family and school relationships, or indirect interaction, such as cultural beliefs. With that in mind, EST provides a lens through which to understand how child, family, teacher, economic, and cultural factors exist in various systems and affect the school reintegration process.

Needs Assessment

The review of current literature revealed that teachers interact with students on a daily basis and, therefore play a role in the recognizing students' mental health needs. Teacher factors provide an entry point into investigating elementary student school reintegration. Although

elementary teachers may recognize mental health concerns, research shows that they often lack efficacy and knowledge responding to symptoms of mental health disorders (Alisic, 2012; Clemens et al., 2011; Reinke et al., 2011; Walter et al., 2006). The needs assessment utilized a convergent parallel mixed methods design, administering a quantitative mental health survey with beliefs and attitudes, knowledge, and self-efficacy subscales to elementary teachers (N=46) in a Midwest public school district. Furthermore, the researcher conducted a semi-structured focus group with elementary teachers who had direct experience with the student reintegration process. The results indicated that teacher did not feel confident in working with students with mental health symptoms, especially externalized behaviors. Teachers also reported in the survey and focus group that they wanted professional development on the topic of student mental health.

Research Purpose and Objectives

The needs assessment findings combined with literature about elementary teachers' limited knowledge and self-efficacy (e.g., Reinke et al.,2011) revealed the need for teacher professional development to increase elementary teachers' knowledge and self-efficacy in working with students with mental health disorders. The purpose of the current study was to examine the impact of teachers' participation in a mental health professional development intervention on their ability and self-efficacy in recognizing and responding to student mental health needs. The objective of the intervention was to increase teachers' knowledge of mental health disorders and symptoms, as well as increase teachers' self-efficacy in responding to internalized and externalized disorder symptoms. Based on the idea of knowledge construction through social interaction applied practice (Lave & Wegner, 1991), as well shared expertise in mental health (Weston et al., 2008), the intended long-term goal associated with the study elementary students will have successful reintegration into the school setting following

psychiatric hospitalization for elementary students. However, because successful reintegration is a distal outcome, the study focused on proximal outcomes related to teacher knowledge and self-efficacy.

Four research questions guided the intervention study. Specifically, this study focused on two process evaluation questions and two outcome evaluation questions:

Process evaluation question one: What proportion of the target population participated in each PD session?

Process evaluation question two: To what extent were the learning objectives met each PD session?

Outcome evaluation question one: To what extent did the participation in the PD sessions influence teacher knowledge of childhood mental disorders symptoms and signs of student distress?

Outcome evaluation question two: To what extent did participation in the PD sessions influence teachers' self-efficacy in recognizing and responding to childhood mental health disorders and signs of student distress?

Research Design

To gain insight into these research questions, the research design included a convergent parallel mixed methods design (Lochmiller & Lester, 2017). Pre-intervention data about teachers' mental health knowledge and self-efficacy was collected using quantitative surveys. Additionally, post-intervention quantitative and qualitative were collected via mental health surveys and semi-structured focus groups. The convergent parallel design allowed for quantitative and qualitative data to be collected in the same phase of research, as well as weighted equally (Lochmiller & Lester, 2017). Additionally, the quantitative and qualitative data

were analyzed independently then interpreted together to understand key findings (Creswell & Plano Clark, 2018).

Intervention

Elementary teachers (*N=10*) from a public-school district in a midwestern state volunteered to participate in professional development sessions from January through June 2020. The mental health sessions were based on elements of effective professional development, including active learning, content based, and extended duration, that research shows lead to changes in teachers' knowledge and self-efficacy (Guskey, 1984; Desimone, 2009; Tschannen-Moran & McMaster, 2009). The learning activities within each session were based on information and strategies from the Heart of Learning and Teaching; Compassion, Resiliency, and Academic Success (Wolpow et al., 2016) and the Be You program (Australian Government National Support for Child and Youth Mental Health Program, 2019). Each session included a 2.5-hour session dedicated to a learning about a specific mental health disorder, as well as classroom behavior strategies. Additionally, the original intervention design included classroom embedded strategy practice. However, due to COVID-19 school closures, classroom embedded practice completed during the first two months of the intervention. Similarly, due to school closures, the intervention transitioned from in-person sessions to online learning via Zoom.

Data and Data Analysis

Being a mixed methods design, the study data relied on both quantitative and qualitative data. The data included pre and post-intervention scores related to teachers' mental health knowledge and self-efficacy. Quantitative data also included attendance information to examine dose. Statistical analysis of this quantitative data included descriptive statistics, as well as

dependent t-tests for pre-posttest comparisons. Qualitative data included exit-tickets, or short reflections that indicate participants' understanding and learning during each session. Furthermore, the researcher conducted a semi-structured interview at the conclusion of the intervention. Exit ticket and focus group responses were studied using emergent coding (Miles et al., 2013).

Findings

The quantitative results evidenced statistical improvement in teachers' knowledge in mental health symptoms on five of the ten items on the Mental Health Literacy Scale (O'Connor & Casey, 2015) related to mental health symptom recognition. Statistical significance was also shown between pre and posttest data on the Teaching for Efficacy for Inclusive Practices (Sharma et al., 2012) scale. Qualitative findings revealed that mental health identification and misconception clarification were addressed through the intervention. Likewise, information and strategy applicability influenced teacher self-efficacy in responding to symptoms in classroom settings.

The current study provided an opportunity for elementary teachers to participate in an intervention pertaining to student mental health. While the key findings show improvements in teachers' knowledge and self-efficacy in recognizing and responding to student mental health needs, the small sample size and lack of control group limit the study's generalizability. However, the study offers implications for practice and research. Specifically, the findings suggest that elementary teachers' knowledge of mental health symptoms and classroom strategies to respond to student needs increased through the intervention, which utilized elements of effective professional development.

CHAPTER ONE

Review of Current Literature

Currently, over 15% of school-age children are diagnosed with some form of mental, behavioral, or developmental disorder, including Attention Deficit Hyperactivity Disorder (ADHD), mood disorders, and conduct disorder (Bitsko et al., 2016; Merikangas et al., 2010). Children who experience acute symptoms and behaviors, including aggression, self-harm, or suicide ideation related to these disorders may require psychiatric hospitalization for psychiatric stabilization (Balkin & Roland, 2007). In recent years, the number of children requiring psychiatric hospitalization has increased (Chun et al., 2016; Grupp-Phelan et al., 2007). The prevalence of pediatric psychiatric hospitalizations increased by 24% between 2007 and 2014 (Chun et al., 2016). While awareness of student mental health needs has increased, the likelihood of elementary students with mental health disorders receiving appropriate and adequate school-based intervention remains low (Clemens et al., 2011). Misinterpretation of symptomology and dichotomy of staff roles often create barriers to school reentry for this marginalized population of students when returning to school after psychiatric hospitalization (Savina et al., 2014). Children with psychiatric issues are often identified merely as having a lack of discipline or being unmotivated to learn (Pescosolido, 2013), leading to the notion that negative behavioral expressions are intentional (Rossen & Cowen, 2015). Misidentified symptoms and confusion in staff roles result in elementary school unpreparedness to implement fitting settings that facilitate continuity of care and transference of treatment gains into the school setting (Simon et al., 2010). Moreover, students can experience devaluation and isolation from peers in school social environments (Moses, 2009). In the professional context of Lake Public Schools (LPS; a

pseudonym) children struggle to reintegrate into school and classroom cultures after psychiatric hospitalization, experiencing social, academic, and continued medical needs.

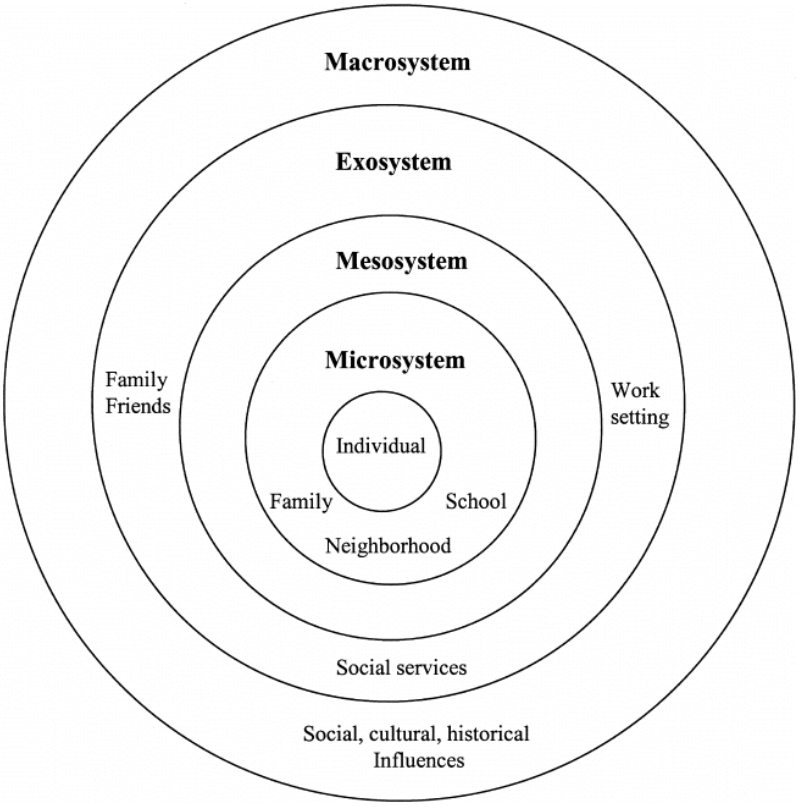
Students admitted to pediatric psychiatric hospitalization face challenges post-discharge, such as transitioning back into pre-hospitalization environments and attempting transfer treatment gains. As elementary age children reintegrate into the school and classroom settings, several crucial factors impact their success. The dynamic interplay of factors, including stabilization of symptoms, preparedness of receiving school staff, and level and quality of parental involvement affect adjustment and transition success. (Savina et al., 2014). While this is true, current research often approaches these factors from the adolescent development level. As such, literature in this synthesis has a heavier emphasis on adolescent perspectives. However, research does provide information and insight on the factors surrounding young children.

Theoretical Framework: Ecological Systems Theory

The school reintegration process involves multiple stakeholders, including families, teachers, and administrators, as well attendance and special education policies established by state and federal laws (Savina et al., 2014). Children with mental health disorders report feeling concerned about family and peer relationships in classroom settings (Preyde et al., 2018). Likewise, parents of children with mental health disorders state trepidation in working with school staff to meet their child's needs, while school administrators illuminate the need to consider financial obligations when providing interventions for students returning to the classroom (Clemens et al., 2011). The interactions between these relationships and environments influence the processes and conditions that shape a child's reintegration process (Savina et al., 2014).

Figure 1

A representation of Bronfenbrenner's (1979) Ecological Systems Theory



Bronfenbrenner's (1979) ecological systems theory (EST) states that children interact in multiple social systems where individual characteristics and environmental dynamics influence their experiences and wellbeing. Specifically, EST describes nested networks including the microsystem, mesosystem, exosystem, and macrosystem that create an individual's environment. Figure 1 shows a graphic representation of EST. The EST perspective considers the social systems and complex interactions in which children are embedded that influence their development (Bronfenbrenner & Morris, 2006). Such social systems and interactions with peers, school beliefs, and cultural attitudes play a role in the expectations related to the school reintegration process (Savina et al., 2014).

Individual

According to EST, social systems center around the individual (Neal & Neal, 2013). Specifically, a child's characteristics influence life experiences and development within different environments (Bronfenbrenner & Morris, 2006). The conceptualization of individual characteristics includes disposition and resources (Bronfenbrenner & Morris, 2006). Disposition refers to the tendency for a child to behave in a particular manner, influencing social interactions with others in a variety of environments (Neal & Neal, 2013). Resources include a child's ability, knowledge, and skills that are required for interacting with others in a variety of settings at any given stage of development (Neal & Neal, 2013). With that in mind, resources include self-process, including emotion, behavior, and cognition to facilitate a child's academic and social functioning in classroom and school settings (Carpenter-Song, 2009). Current literature suggests that for children with mental health issues, psychiatric disorder diagnosis and severity of symptoms also influence experiences and development (Carpenter-Song, 2009; Crosby, 2015; Moses, 2009; Preyde, Parekh, & Heintzman, 2018; Savina et al., 2014).

Microsystem

EST posits that a child's development is influenced by interacting natural contexts in which children live, work, and play (Bronfenbrenner, 1979). The microsystem consists of the direct actions, reactions, and interactions a child has with the physical and social features of the immediate environment (Bronfenbrenner, 1994). Factors within the child's immediate environment, include family, peers, and school settings and relationships (Bronfenbrenner, 1994).

For a child with mental health disorders requiring psychiatric hospitalization, the microsystem also includes the hospital setting, including hospital staff and personnel (Savina et

al, 2014). With that in mind, hospitalized children must adjust emotionally from the absence of family members and the school relationships (Moses, 2011). Children may experience disruptions at discharge associated with losing supportive relationships with hospital staff (Savina et al., 2014). From an EST perspective, transitions create disequilibrium between a child and the microsystems to which the child belongs because it requires the child to have the ability to adapt to new environmental demands (Bronfenbrenner, 1979).

Mesosystem

The mesosystem encompasses the links between multiple settings in which the child actively participates (Bronfenbrenner, 1979). For example, interrelations may include relations between home, school, and peer groups (Bronfenbrenner, 1994). In other words, a mesosystem is comprised of a system of microsystems (Neal & Neal, 2013). For example, relationships and interactions between caregivers and school personnel represent a mesosystem. Relationships between caregivers and school staff influences information sharing and how parents are involved in the decision-making process along with teachers and school administrators creating a school reintegration plan (Blizzard et al., 2016; Ohan et al., 2015).

Exosystem

While microsystems and mesosystems directly include the developing child, the exosystem does not necessarily include the developing person as an active participant in the settings (Bronfenbrenner, 1979). Specifically, the exosystem includes two or more settings, including one which does not include a developing child (Bronfenbrenner, 1979 Bronfenbrenner, 1994). Although the developing child is not an active participant in the exosystem settings, the relationships and events in these settings indirectly influence development (Bronfenbrenner, 1994).

To that end, insurance policies influence the length of hospitalization, and prescription coverage (DeRigne, 2010). Similarly, school and special education policies enacted by state and federal laws affect the reintegration process through established mandatory school attendance requirements, as well as available school services (Savina et al., 2014). While the child does not directly interact with organizations creating policies and laws, the results influence the extent of hospitalization, continuity of care, and school supports (Blizzard et al., 2016).

Macrosystem

School and classroom environments include a variety of beliefs, attitudes, and actions toward students with mental health disorders (Bellanca & Pote, 2013; Savina et al., 2014). Teachers and peers interact with children with mental health disorders depending on their perceptions of the cause of mental health disorders, as well as the extent to which children can control symptoms (Silberman, 1969). Such beliefs and attitudes comprise the macrosystem (Bronfenbrenner, 1979). Specifically, the macrosystem envelops other social systems that influence a child's development (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Keeping that in mind, the macrosystem consists of the overarching belief systems, attitudes, knowledge, and customs characteristic of a given culture (Bronfenbrenner, 1994). For children returning to school following psychiatric hospitalization, the preparation and beliefs of the receiving teachers and peers influences the successfulness of school reintegration (Savina et al., 2014).

Children reintegrating into the school following psychiatric hospitalization must navigate peer and teacher relationships, as well as school academic and behavioral expectations (Preyde, et al., 2018). With that in mind, examining school reintegration through the EST lens illuminates such factors as the perception of psychiatric hospitalization by children and preparedness of schools to receive a child discharged post-discharge (Savina et al., 2014). Further, it requires the

understanding of children's academic and social-emotional needs, as well designing interventions which promote children's adjustment to school requirements, and creating a supportive school environment. As such, this literature review focuses on understanding how the individual, microsystem, macrosystem, exosystem, and macrosystem influence school reintegration. Specifically, the literature review explores how factors at the child, family, teacher, economic, and cultural level influence the academic, social, and emotional needs as the child transitions back into the school and classroom settings.

Child Factors

Approximately six to nine million, or 17% of children are diagnosed with mental health disorders (Centers for Disease Control, 2020; Simon & Savina, 2005). Children with these mental, behavioral, or developmental disorders often exhibit internalized or externalized symptoms. Internalized symptoms include depressive symptoms, social withdrawal, or somatic complaints, whereas externalized symptoms manifest as disruptive behaviors such as theft or physical aggression (Simon and Savina, 2010). While mental health services can be delivered in many settings to help ameliorate these symptoms, the most severe require psychiatric hospitalization (Grupp-Phelan et al., 2007). In fact, more than 140,000 children receive inpatient psychiatric treatment each year (Savina et al., 2014). According to the EST framework, understanding a child's specific characteristics and functioning provides insight into how they navigate environments, such as school settings (Bronfenbrenner & Morris, 2006). When returning to school, continued symptomology, academic performance, and social functioning influence reintegration at the student level (Preyde et al., 2018).

Continued Symptomology

While inpatient psychiatric treatments aid in the stabilization of symptoms, they do not necessarily prepare students to return to school post-discharge (Clemens et al., 2011; Moses, 2011a). In fact, readiness to return to school is typically not considered part of discharge criteria (Clemens et al., 2010). However, school reentry occurs shortly following discharge, readiness to manage academic, social, and personal needs notwithstanding. Following hospital discharge, children often continue to experience mental health symptoms which affect their ability to engage in school activities and navigate the school environment (Clemens et al., 2010). As students return to school with on-going symptoms, they might exhibit internalized or externalized behaviors. Students may display disruptive, anxious, argumentative, withdrawn, aggressive, rule-breaking, inattentive, or manipulative behaviors (Simon & Savina, 2010). Moses (2011a) conducted semi-structured interviews with 213 adolescents hospitalized for suicide ideation, suicide attempt, or aggressive behaviors. The youth noted that they felt they did not receive enough treatment and 25% of the participants expressed psychiatric symptoms at the time of discharge. Additionally, students with pharmacological treatment for symptoms may experience side effects such as lethargy which may also impact their ability to successfully interact with teachers and peers within the school environment (Clemens et al., 2011).

Not only can students exhibit continued mental health disorder symptoms post-discharge, but interaction within the school environment can provoke symptomology. It is common for students to display signs of being emotionally overwhelmed by being in the school setting again (Clemens et al., 2010; Simon & Savina, 2010). Specifically, returning to school after prolonged absences, such as hospitalization, results in increased workload and tension of how to explain the absence to peers (Clemens et al., 2010; Savina et al., 2014; Simon & Savina, 2010). Such

tensions exacerbate feelings of anxiety and maladaptive behaviors (Savina et al., 2014). Preyde et al., (2018) confirmed this in a recent study of 121 youth who had negative transition experiences. The researchers used The Strengths and Difficulties Questionnaire (SDQ), which has five subscales: emotional problems, hyperactivity, conduct problems, peer problems, and prosocial behaviors. Students completing the youth self-reported SDQ reported feelings of extreme stress and despair during the reintegration process, aggravating their disorder symptoms. The transition process led to increased feelings of anxiety, moodiness, temper, and poor concentration.

Continued psychiatric symptoms also increase the risk of rehospitalization, especially within 90 days post-discharge (James et al., 2010). Students who experience severe psychiatric symptoms and experience rehospitalization face additional time away from school. Similarly, a study conducted by Simon and Savina (2007) postulated that aftercare services such as counseling and medication management are essential for students returning to school to retain and transfer treatment gains. While Clemens et al., (2011) concurred that while aftercare is necessary for managing symptoms, it can result in inconsistent student attendance during the reintegration process because of counseling and other treatment appointments. Additional time away from school, through rehospitalization or other treatment, creates further distance from peers and teachers within the school environment (Simon & Savina, 2005).

Academic Concerns

Many students returning to school after hospitalization find the environment daunting when they are unable to meet academic expectations (Lane et al., 2008). Clemens et al., (2010) posited that often make-up work cannot be completed during the absence and, therefore, assignments are compounded when the student returns to school. Absences create workload

increases and challenges in completing missed work (Preyde et al., 2018; Savina et al., 2014). Thus, upon reintegration, children may feel overwhelmed by catching up on missed academic content.

Additionally, mental health conditions may affect a child's cognitive and academic functioning. Some students with psychiatric disorders may display impaired receptive and expressive language skills (Savina et al., 2014). Anxiety and depression may interfere with working memory (Owens et al., 2012). Similarly, students with depression may also exhibit reduced processing speed and executive functioning skills (Brooks et al., 2010). Therefore, it is not uncommon for children to have preexisting academic challenges before hospitalization.

In recent years, academic performance of students with various diagnoses has become an interest to researchers, including the prevalence of learning disabilities in children with mental health disorders (Lane et al., 2008). Students with such diagnoses as bipolar disorder and Attention Deficit/Hyperactivity Disorder (ADHD) tend to have high percentages of learning disabilities (Mayes & Calhoun, 2006). While this is true, students with anxiety disorders seem less likely to experience academic difficulties (Mychailyszyn et al., 2010). Of content areas, written expression appears to be among the most difficult for children with mental health disorders (Mayes & Calhoun, 2006). A study by Lane et al., (2008) revealed that students with emotional and behavioral disorders scored below the 25th percentile on the Woodcock-Johnson Test of Achievement in reading, writing, and mathematics. Students with a higher level of school adjustment also had a higher level of writing performance; additionally, students with internalized behaviors had higher reading levels than students with externalized behaviors (Lane et al., 2008). Unlike these studies, Preyde et al., (2018) indicated that some students returning to school do not exhibit any learning difficulties. Preyde and colleagues (2017) also postulate that

some students are high academic achievers and may be very successful academically when returning to school.

As students reintegrate into school and classroom culture following hospitalization, it is important to note that these academic functioning impairments will continue post-discharge (Mychailyszyn et al., 2010). Preexisting learning difficulties are not remedied with psychiatric treatment. For children who have learning difficulties or stressors, additional appropriate accommodations may be needed to meet their learning and mental health needs (Clemens et al., 2010). Instructional accommodations such as increased time for task completion, frequent breaks, and reduced linguistic complexity for directions may be effective classroom strategies (Savina et al., 2014).

Social Functioning

Furthermore, children returning to school and classroom settings commonly exhibit social functioning issues, including isolation and strained friendship development (Clemens et al., 2010). As mentioned earlier, research suggests that students often are unsure of how to explain their absence to teachers and peers (Clemens et al., 2011, Preyde et al., 2018; Savina et al., 2014). Because of concerns of rejection, students may even lie or attempt to keep their hospitalization a secret (Moses, 2009).

In a study by Moses (2009), students ages 12-18 with at least one affective or behavioral disorder who received integrated psychiatric treatment were interviewed to understand how youth conceptualize their diagnoses, as well as how self-labeling and self-stigma create barriers for continued service utilization. Modified labeling theory, which posits that individuals diagnosed with mental health disorders are susceptible to developing negative self-concepts and internalizing stereotypes, informed the study. During the study, data were collected using the

Rosenberg Self-Esteem Scale, Perlin Mastery Scale, Child and Adolescent Functional Assessment, Center for Epidemiologic Studies- Depression, and Self-Stigma Scale. The key findings suggest that students who did self-label were primarily white students and were diagnosed at a younger age. Adolescents who self-labeled expressed higher rates of rejection or isolation and showed higher rates of self-stigma, resulting in depressive symptoms. As a result, these students often attempted to conceal psychiatric treatment, including hospitalization.

Some children who require psychiatric hospitalization may even see their diagnosis and treatment as a failure in their character (Savina et al., 2014). As such, students begin to develop negative self-concepts and internalize stereotypes about mental health disorders (Moses, 2009). Thus, students see themselves as flawed, rather than having a medical condition (Carpenter-Song, 2009). With negative self-concepts, students tend to withdraw from social situations and people that they feel will judge them on their diagnoses (Link et al., 2001). This includes withdrawing from peer and teacher interactions during the transition process (Clemens et al., 2010).

Family Factors

As part of the microsystem, family is part of a child's immediate environment (Bronfenbrenner, 1979). With direct interactions with the child, family involvement and decision-making play a significant role in the hospitalization and school reintegration process. While parents report their child's behavior prompted psychiatric hospitalization (Golubchik et al., 2013), they often feel guilt associated with that hospitalization (Dalton et al., 1989). Research suggests that parents' inability to cope over behavior and guilt associated with treatment leads to diminished involvement and communication with school staff during the reintegration process (Blizzard et al., 2016; Brannan & Heflinger, 2006; Minnes et al., 2015). Additionally, as study

by Eaton and colleagues (2017) showed that parents may worry about how school staff will stigmatize them for their child's mental health needs, decreasing the likelihood that parents will communicate with school staff about their child's diagnoses, symptoms, or behaviors. Pierre Bourdieu (1974) notes that individuals draw upon their background experiences and resources, also known as capital, in social situations. Bourdieu (1974) argues that differences in capital, such as social connections, educational skills and attainment have different value in society. A study by Trainor (2010) supported Bourdieu's assumptions by showing that differences in cultural capital influence caregiver ability to interact with clinical and school staff in effective decision making. With that in mind, it is important to consider family involvement, communication, and education concerns in light of understanding unsuccessful student reintegration.

Family Involvement

Caregiver involvement in their child's treatment plays a significant role in access to psychiatric care post-discharge. In a study by Blader (2004), 109 children were followed for one year after being discharged from psychiatric hospitalization. The purpose of the study included understanding risks of rehospitalization, as well as timing of rehospitalization. Quantitative measures included the Child Behavior Checklist, as well as the Kaplan Meijer curve for measuring rehospitalization risk. Children of caregivers with high involvement, such as interacting with providers, in the decision making process with providers, and consistent symptom monitoring, were more likely to continue outpatient individual or family psychosocial treatment after hospital discharge. Likewise, these students are less likely to be readmitted, especially within 90 days post-discharge (Blader, 2004; James et al., 2010). Unlike high involvement caregivers, studies show that students with low involvement caregivers (not

monitoring child symptoms or not cooperating with providers) are at a higher risk of rehospitalization (Blader, 2004; Golubchik et al., 2013). Low Involvement parents are also less likely to maintain consistency in treatment and interventions (Golubchik et al., 2013).

Caregivers experiencing moderate strain are more likely to be involved in treatment, continuity of care, and the decision-making process for their children (Brannan & Heflinger, 1997; Brannan & Heflinger 2006; Golubchik et al., 2013; Heflinger et al., 1996). Specifically, Brannan, Heflinger, and Bickman (1997) suggest that caregiver strain refers to the responsibilities, demands, and psychological demands that accompany caring for a child with special needs, including mental health disorders. While it seems counterintuitive, caregiver strain increases the chance that a child will receive therapeutic care (Golubchik et al., 2013).

Brannan et al., (2003) designed a study grounded in the Double ABCX theoretical framework, which helps to describe how families respond to life stressors, such as having a child with emotional and behavioral problems. The framework recognizes the interrelatedness of factors both inside and outside of the family (McCubbin & Patterson, 1982). The purpose of the study was to know how families react to stress, such as having a child with mental illness, outside stressors, and how both impact continuity of mental health service usage. The study revealed that when caregivers experienced high levels of subjective strain, such as conflicting feelings about hospitalization and treatment, children had gaps in treatment and psychiatric care after hospitalization. Similarly, the study revealed that when caregiver strain is both especially high or low, children also experienced gaps in care. Additional studies confirm similar conclusions that low strain results in gaps in treatment (Blader, 2006; Brannan & Heflinger, 2006). When caregivers do not experience high or low levels of strain they are less engaged in the treatment process and do not view clinical help as necessary (Blader, 2004). However, when

parents experience high levels of distress, they discontinue treatment due to feeling overwhelmed accessing services and meeting their child's needs (Brannan & Heflinger, 2003; Golubchik et al., 2013).

Moreover, caregiver expectation of treatment creates barriers to the reintegration process. Some parents expect that short-term hospitalization will "fix" the disorder and, thus, lack the understanding that students need assistance transitioning back into the school setting (Clemens et al., 2011). Additionally, conceptualization of their child's mental health disorder can impact their coping responses to the diagnosis. While some parents conceptualize their child's mental health problems in medical or psychiatric terms, some view them as normal adolescent behavior (Moses, 2011b). Parents who consider their child's problem as normal adolescent behavior tend to seek out pharmacological treatment for their children as a primary manner in controlling symptoms and do not view other treatment as helpful (Moses, 2011b). Through their study, Golubchik et al., (2013) confirms that caregiver capacity to understand the child's diagnosis and symptoms impacts the likelihood that elementary-age children will receive appropriate treatment. Furthermore, caregiver rejection or acceptance of the diagnosis shapes parental empathy expressed toward the child suffering from the symptoms (Golubchik et al., 2013). Understanding and response to child diagnosis and symptoms influences parents' response and involvement with decision making during hospitalization and the school reentry process (Clemens et al., 2011).

Educational Concerns

In the EST framework, the mesosystem is the interlinked system of microsystems in which a child participates (Bronfenbrenner, 1979). With that in mind, the mesosystem includes linkages between family and school, as caregivers and school staff interact throughout the

reintegration process. Interactions between caregivers and school staff include communication and academic program planning (Clemens et al., 2011).

In response to semi-structured interview questions and quantitative scales, caregivers express that they lack social support systems to help with their child's mental health issues (Blizzard et al., 2016). Specifically, a mixed methods study conducted by Blizzard and colleagues (2016) examined the effectiveness of the School Transition Program (STP), an intervention designed to support children and families after psychiatric hospitalization. The researchers recruited 114 caregivers of children receiving inpatient psychiatric care in both urban and suburban facilities. To develop a greater understanding of the STP program, the researchers administered the Strengths and Difficulties Questionnaire Parent Version (SDQ; Goodman, 1997), The Child and Adolescent Services Assessment (CASA; Ascher et al., 1996), Caregiver Strain Questionnaire-Short Form (CGSQ-SF; Brannan et al, 2012), Family Support Scale (FSS; Dunst et al., 1984) Family Empowerment Scale (FES; Koren et al, 1992), the Brief COPE (Carver, 1997), and the Youth Satisfaction Survey for Families (YSS-F; Riley et al., 2005). Caregivers also answered four open-ended interview questions pertaining to their perceived needs after discharge, support systems after discharge, school expectations after discharge, and expectations of their STP participation. Results showed that single, separated, or divorced caregivers often report low encouragement in seeking mental health and educational services for their child after hospital discharge. Additionally, parents with limited support, parents also lack confidence in advocating for appropriate educational services for their child during the transition process. According to questionnaire and interview responses, many caregivers reported "needing assistance in advocating for themselves and their children in the school setting" (Blizzard et al., 2016, p. 775).

Furthermore, as Trainor (2010) suggests, when students receive Special Education services, many caregivers lack the social and cultural capital to navigate the IEP process. Trainor's (2010) ethnographic study was designed to gain a better understanding of parental involvement in the IEP process required by the Individuals with Disabilities Improvement Act of 2004. Bourdieuian capital theory framework was used to support the study. Bourdieuian capital theory posits that the social assets of a person, such as education, intellect, style of speech and dress, etc., influence social interactions within a stratified society. As the researcher conducted semi-structured interviews and focus groups with 27 families, results illuminated that parents often were not familiar with the language used in IEP meetings and did not understand the services their children would receive. Also, some caregivers, especially those from marginalized populations, felt that their child's needs would be neglected. As Trainor (2010) notes, "because special education services and accommodations require resources of time, effort, and money, conceivably limited in supply, power differentials between and among parents and teachers potentially influence who gets what" (p. 246).

Along with that, it is not uncommon for parents to express concerns that schools lack confidentiality when working with children (Blizzard et al., 2016) and therefore may not disclose the information needed to secure educational resources for reintegration. Primarily, parents express concern that teachers will share their child's information with other teachers (Ohan et al., 2015). Thus, caregivers report that they feel more comfortable sharing mental health information with practitioners than school psychology staff (Ohan et al., 2015). Moreover, mothers determine when to disclose or conceal information based on helping the child obtain school services (Blizzard et al., 2016; Eaton et al. 2017; Ohan et al., 2015). However, they only reveal as much information as they deem relevant (Eaton et al., 2017). Parents report that school staff should be

aware of mental health needs at the time of reintegration but are reluctant to share information about treatment and diagnosis (Kramer et al., 2006). Limited information sharing with school staff at the time of reintegration may come as a result of fears of stigmatization by school staff and other parents. However, sharing mental health information allows teaching staff to prepare for behavioral and academic needs of the student before a return to the classroom (Clemens et al., 2010).

Teacher Factors

As children transition into the school setting post-discharge, they will interact with teachers daily. Teachers are part of the microsystem, meaning that they are a direct part of a child's environment (Bronfenbrenner, 1979). As such, teacher relationships are one of the primary relationships students have in the school and classroom settings. Teachers are often expected to influence decision making and facilitate symptom management and academic progress in classroom settings. Research indicates that often teachers suggest that they are ill-equipped to manage student mental health needs in the classroom (Alisic, 2012; Buell et al., 1999; Reinke et al., 2011). With that in mind, it is necessary to consider teacher factors that impact student reintegration, such as teacher beliefs and attitudes, teacher efficacy in meeting student mental health needs, and teacher training.

Teacher Beliefs and Attitudes

As students return to the classroom, teacher attitudes toward students with mental health needs and their role and responsibility in managing student emotional and behavioral issues impact the successfulness of the reintegration process (Clemens et al., 2011). With that in mind, current literature shows that teachers often believe that the school psychologist, not the teacher, is the primary staff member responsible for addressing student mental health needs (Alisic, 2011;

Reinke et al., 2011; Rossen & Cowen, 2014). Using a qualitative design, a study by Alisic (2012) examined teachers' perspectives and beliefs toward working with students with mental health issues. Twenty-one teachers from 13 schools participated in semi-structured interviews related to their experiences, beliefs and feelings, and information needs of working with students with mental health needs. Key findings of the interviews showed that many teachers believe their role is to provide academic instruction, whereas school psychologists and social workers should be providing social and emotional support. Specifically, several teachers reported in the interviews that they believed that teachers' roles were moving away from academic instruction and playing a larger role in social and emotional development. While participants noted that social and emotional development is important, they felt that school staff roles should be based on specific expertise.

Such beliefs toward mental health needs and classroom inclusion practices can be evident toward students within the classroom. In a seminal study by Silberman (1969), the author studied teacher attitudes (i.e., attachment, concern, indifference, and rejection) toward inclusion students. The author designed a mixed-method study and purposively selected ten third grade teachers from five different suburban communities in the greater Chicago area. To begin, the researcher interviewed teachers individually about attitudes they had regarding students; classroom observations followed soon after interviews. Research assistants studied teacher gestures, tone of voice, and words directed at four targeted and two control students uncovered by the teacher interview. Key findings revealed that teachers spent a greater amount of time and contact with students they had concern for, while they had less contact with students towards which they felt indifference. Teachers treated students in the rejection group with negative evaluation, such as

criticism. Teachers did not exhibit less contact with these students but did expel these students from class more frequently than other students.

To build on the Silberman (1969) study, Cook, Cameron, and Tankersley (2007) designed a study to measure the level of attachment, concern, indifference, and rejection teachers exhibited toward elementary students with and without disabilities. Fifty elementary teachers across 12 schools in Ohio participated in completing a four-point Likert scale. The scale was administered during the first half of the year and again seven weeks after the initial survey. The results illuminated that teachers expressed more rejection toward students with disabilities, such as mental health disorders, than those without disabilities. The theoretical model of instructional tolerance guided this study. This theory posits that given finite resources, such as time and expertise, and significant variances in student learning characteristics and achievements, teachers will not provide optimal learning instruction to all students at the same time (Cook et al., 2007). With that in mind, Cook et al., (2007) suggested that students with disabilities will likely consistently fall outside of a teacher's boundaries of instructional tolerance, influencing a teacher's attitude. Several other studies postulate that teachers believe that students with mental health issues in general classrooms, particularly those with externalized behaviors, are problem students, requiring more effort and making it more difficult to teach in the classroom (McLeod et al., 2012; Rossen & Cowan, 2015; Savina et al., 2014).

Teacher Efficacy

As students reintegrate after psychiatric hospitalization, teachers are expected to assume the role of educators, as well as observe mental health symptoms and refer students for mental health services (Rothi et al., 2008). It is essential to consider teachers' efficacy in meeting student academic, social, and emotional needs upon student return. Many teachers report low

self-efficacy in working with children with mental health issues, specifically managing externalized behaviors (Alisic, 2011; Clemens et al., 2011; Reinke et al., 2011; Walter et al., 2006). Through semi-structured interviews, teachers note acceptance of having a degree of responsibility in being able to assist students with mental health needs; however, they do not believe they can adequately recognize symptoms or implement behavioral strategies in the classroom (Rothi et al., 2008).

Teachers feel they lack strategies for deescalating heightened behaviors (Alisic, 2012; Crosby et al, 2015: Reinke et al., 2012; As a result, general education teachers note that they are unsure how to help children become re-established in school, especially how to respond if a child was having difficulty (Alisic, 2012; Walter et al., 2006). Teachers feel unsure of how to help children is especially true when students exhibit violent and disruptive behaviors (Walter et al., 2006). However, current research indicates that special education teachers tend to have more confidence in teaching students with mental health needs, including those with emotional and behavioral impairments (Buell et al., 1999, Clemens et al., 2010).

To gain a better understanding of teacher self-efficacy in providing mental health support to students, Graham, Phelps, Maddison, and Fitzgerald (2011) conducted a quantitative study. Participants were 508 elementary and secondary teachers across 40 school districts. Teachers were asked Likert-scale and open-ended questions about their beliefs about student mental health, willingness to provide mental health education, role in providing emotional and behavioral supports for students, and confidence in mental health education. The majority of teachers (89%) noted that schools should provide services for students who have mental health needs). However, only 22% of teachers expressed that they felt very confident in their ability to meet student needs. Teachers with low self-efficacy tended to be unwilling to engage in or

support mental health education in general education classrooms. They expressed that mental health needs were a medical problem to be addressed by counselors and medical professionals, not school staff. Likewise, teachers with low self-efficacy expressed conflict about their role in teaching and providing mental health support to students. Some believed their role should be meeting academic needs, regardless of training they had received.

In general education classrooms, some teachers lack efficacy in being able to balance meeting one child's mental needs while still meeting the demands of the rest of the class (Avramidis et al., 2000). Teachers may feel like student mental health needs take over their time, especially those students who exhibit acting out behaviors (Alisic, 2012; Clemens et al., 2011). Teachers suggest that they do not have the confidence necessary to meet the typical classroom demands, such as teaching the curriculum and manage social and behavioral supports and interventions involved with having a student with mental health needs (Reinke et al., 2011).

New teachers express frustration in being overwhelmed by needing to learn the curriculum and school procedures along with how to meet the needs of students with difficult behaviors (Crosby et al., 2015). A study conducted by Avramidis et al., 2000, examined self-efficacy of novice teachers when working with students with special needs, including mental health disorders. The researchers administered the Opinions Relative to Mainstreaming scale (Larrivee, 1982) to 132 preservice and novice teachers. The scale measured teachers' confidence in managing students' emotional reactions to stressors, as well as teachers' confidence in meeting collaborating with ancillary staff and meeting Individualized Education Programs (IEP) requirements. Results show that teachers expressed difficulty in creating a welcoming classroom environment for students with learning needs, particularly those with emotional and behavioral impairments. Furthermore, key findings show that teachers felt they needed resources, such as

paraprofessionals and additional differentiated teaching packages to feel successful, especially when teaching students with emotional or behavioral impairments.

These results reflect a similar study conducted by Buell et al., (1999). Buell and colleagues (1999) examined teachers' confidence regarding student success in inclusive settings, as well as teachers' perceptions of their needs. Through 508 teacher surveys across 19 school districts, the researchers found that teachers felt they needed additional support staff to increase confidence in working with students with aggressive behaviors. However, the researchers also noted that teachers also felt they needed smaller class sizes and training in implementing IEP goals.

As teachers note that they are ill-prepared to address mental health symptoms, they take these unmet needs seriously (Rothi et al., 2008). In a qualitative study, Rothi et al., purposively sampled elementary and secondary teachers to participate in semi-structured interviews to explore teacher self-efficacy in student mental health management. The interviews illuminated that teachers felt that did not have the ability to meet student needs, which lowered teacher job satisfaction. Participants expressed feeling incompetence and frustration about not being able to meet student needs, which negatively affected their well-being. The majority of teachers reported that they believed that their inability to meet student needs was related to having insufficient knowledge and skills of mental health disorders. Several studies confirm that a lack of self-efficacy in teaching students with mental health needs, including those returning to school after psychiatric hospitalization, is related to limited knowledge and training (Frauenholtz et al., 2017; Clemens et al., 2010, 2011; Reinke et al., 2011; Savina et al., 2014; Simon & Savina, 2010).

Teacher Preparation

The lack of knowledge in identifying mental health symptoms and appropriate interventions becomes a barrier in recognizing and intervening when students are in emotional distress, as well as implementing instructional and behavioral strategies (Frauenholtz et al., 2017). Limited knowledge and awareness to assist children in managing mental health needs in the classroom may have deleterious emotional and academic outcomes (Frauenholtz et al., 2015). As such, research suggests that teacher training and professional development (PD) opportunities are essential (Buell et al., 1999; Clemens et al., 2011; Frauenholtz et al., 2017; Simon & Savina, 2010; Reinke et al., 2011; Walter et al., 2006).

Teachers often report that they do not have the knowledge and preparation in how to successfully implement behavioral interventions for students with disruptive or aggressive behaviors (Reinke et al., 2011; Walter et al., 2006). A study by Frauenholtz et al., (2015) illuminated that teachers had not received adequate training to recognize internalized symptoms of students in distress. Furthermore, teachers, as well as additional school staff such as administrators, social workers, and paraprofessionals did not feel they had enough training to intervene when students exhibited aggressive or violent behaviors. Moreover, general and special education teachers note that they often feel uncomfortable communicating with parents about student behavior and would benefit from additional training to develop communication skills (Buell et al., 1999). This is especially important because the first week of school during the reintegration process often involves intense behaviors and requires communication with caregivers (Simon & Savina, 2010).

Along with training in classroom behavioral strategies to respond to students' needs, current research suggests that teachers lack training in mental health disorder symptomology

(Alisic, 2012; Clemens et al., 2010; Crosby et al., 2015; Savina et al., 2014). Elementary teachers note that they find it difficult to discern between common childhood disorders (Rothi et al., 2008). Specifically, teachers have difficulty recognizing internalizing symptoms which are not as obvious in the classroom setting (Bryer & Signorini, 2011).

As such, teachers are often unable to make appropriate referrals for academic and school social work services. (Frauenholtz et al., 2015). Walter et al., (2006) posited that educators' limited training and knowledge in student mental health prevent them from being able to recognize symptoms associated with various disorders, thus, preventing them from meeting student needs. The Walter et al., (2006) study included 119 teachers in six urban elementary schools in a Midwestern city; 82% of participants were female, and 95% were general education teachers. The mixed-methods study included a survey, interviews, and focus groups aimed at understanding teacher perspectives of mental health barriers to the school setting. Teachers reported disruptive classroom behavior as a major barrier to creating productive learning environments. While teachers stated that they did not feel confident in managing aggressive behaviors, most (77%) reported some experience teaching students with these symptoms. On the other hand, less than half of teachers noted being able to identify symptoms related to anxiety, trauma, or depression. In fact, only 12% of teachers said they could recognize symptoms, including language associated with suicidal ideation. Understanding a child's disorder allows a teacher to prepare for the emotional and behavioral expectations during the transition process, facilitating teacher confidence in working with students with mental health needs and creating behavioral and learning accommodations during the transition process (Simon & Savina, 2005, 2010; Savina et al., 2014).

Conversely, other studies found that some teachers with high to medium knowledge about mental health disorders and symptoms report feeling less confidence in managing children with externalized and internalized behaviors than teachers with low knowledge (Ohan et al., 2008). In fact, teachers with limited training and knowledge were less likely to seek help for students than those with more education (Ohan et al., 2008). The reason for this may be that teachers with low levels of education and knowledge may be overconfident in their ability when working with students with special education needs or may not recognize the seriousness of the disorder (Avramidis et al., 2000; Ohan et al., 2008).

Additionally, medication has become an important aspect of treatment for children with mental health needs (Schoenfeld & Konopasek, 2007). According to teacher responses to semi-structured interview questions, teachers often lack understanding of the side-effects of pharmacological treatment that children may receive post-discharge (Savina et al., 2014; Simon & Savina, 2005; Simon & Savina, 2010). Psychotropic medications can cause lethargy, dizziness, and lack of concentration (Carpenter-Song, 2009; Clemens et al., 2011) that can inhibit learning. Savina et al., (2014) suggest that medication side effects can be associated with difficulty processing information. This is particularly important because, as mentioned earlier in child factors, it is not uncommon for children to experience academic concerns when reintegrating into school and classroom settings after hospitalization. Furthermore, as teachers may be unaware of side-effects such as poor executive functions (Savina et al., 2014), they likely will not be able to support student needs and refer students for necessary academic services.

A study conducted by Rothi and colleagues (2008) indicated that teachers are expected to assume the responsibility of recognition and referral of student mental health problems, however, they do not receive adequate training in recognizing symptoms or classroom strategies. The

qualitative study consisted of semi-structured interviews of 32 elementary and secondary teachers. Qualitative analysis of the interviews revealed four themes including responsibilities, mental health related training, language and discourse, and recognizing mental ill-health. Participants responses to interview questions showed that felt they lacked knowledge, training, and common language surrounding common childhood psychiatric disorders. Specifically, teachers struggled with definition vagueness of the term mental health and when it was appropriate for them to suggest that a child had mental health issues. Furthermore, elementary teacher interviews revealed that training options for student mental health were simply not available; in-service and PD choices centered around content area instruction. Additionally, the study showed that a lack of time was a barrier to attending workshops outside of school hours. Teachers suggested that they were willing to learn about student mental health disorders; however, personal schedules did not permit for outside trainings.

Similarly, Crosby et al., (2015) discovered that teachers felt that districts should provide training in working with students with mental health needs. Their study consisted of five focus groups to understand teacher perspectives about student trauma and behavior, staff training, and staff needs. The study illuminated that 90% of the students with trauma backgrounds had mental health diagnoses and required treatments. Staff wanted information about the impact of trauma on learning and behavior. Many teachers in the study noted that they wanted the district to offer services to meet their needs post-training. They recognized that questions would arise when dealing with students and would like a coach they could access to consult. Reinke et al., (2011) also noted needing follow-up consulting and training to meet student mental health needs. During the reintegration process, then, it seems teachers desire not only more training in

servicing students with mental health issues but also how to translate training knowledge into practice.

Economic Factors

Economic factors impacting families and schools affect the student transition process from psychiatric hospitalization into the school and classroom settings (Snell et al., 2013). Unmet child needs are often a result of family financial stress due to inpatient and outpatient treatment (DeRigne, 2010). Caregivers with both private and public insurance, as well as those who are uninsured, report financial strain leading to child unmet mental health needs (DeRigne, 2010). Unmet needs contribute to continued symptoms during the reintegration process (Clemens et al., 2010). Likewise, schools face financial constraints for providing mental health services for students due to budget cuts (Snell et al., 2013). With continued symptoms and limited school resources, students struggle to reintegrate into the school environment (Clemens et al., 2010, 2011)

Family Financial Barriers

Children with mental health disorders do not interact directly with their family's monetary assets, however as part of a child's exosystem, finances may influence patterns of care the child receives (Bronfenbrenner, 1979; Savina et al., 2014). Cost of treatment and insurance plan issues are the primary economic problems described by caregivers of students with mental health disorders (Brannan & Heflinger, 2006; DeRigne, 2010). In understanding caregiver strain, Brannan and Heflinger (2006) interviewed families of 1,012 with children ages five through 17 who had utilized mental health services. The interviews indicated that state that cost of treatment can create caregiver strain. Specifically, feelings of anger, resentment, guilt, and worry may lead to dissociation with the mental health care system following hospital discharge. Additionally,

inadequate insurance coverage contributes to the high cost of treatment. In a study conducted by DeRigne (2010) insurance status, as defined by whether a child lacked insurance coverage at any point within a 12-month period, was examined to see if the child had any unmet mental health needs. Unmet needs were determined by parental responses to whether or not the child received all the mental health care or counseling needed; if the parent reported that the child did not receive all of the treatment needed, the child was categorized as having unmet needs. The key results illuminated that 25% of caregivers reported that the cost of insurance inhibited providing adequate coverage to meet their child's needs. This result held true for families with both public and private insurance plans. Uninsured families were the most likely to report having a child with unmet needs and stating cost as the primary contributing factor for continued mental health needs. The researcher posits that families discontinue treatment services due to the costs involved. Discontinued care often leads to inconsistent medical management and continued symptoms upon school return (Clemens et al., 2011).

Likewise, as students lack continuity of care based on treatment cost, caregivers also discontinue treatment due to other personal financial burdens, (Brannan & Heflinger, 2006; Busch & Barry, 2007). In a study by Busch and Barry (2007), the researchers compared the financial and time burdens of families of children with mental health disorders to other medical conditions. The researchers hypothesized that caregivers of children with mental health disorders would experience more significant financial strains, more missed hours of work, and more time providing care for their child than parents of children with other conditions. Arranging care, such as appointments, for mental health needs required more time each week than for other chronic health conditions, often requiring caregivers to cut work hours. Loss of work resulted in the loss of wages for over 30% of respondents. To avoid unemployment, some parents opted to cancel

their child's care rather than miss work requirements. Lack of continued care after psychiatric hospitalization creates challenges for children to transfer treatment gains from the hospital into the classroom setting during the transition process (Savina et al., 2014).

School Financial Barriers

Elementary school counselors have a positive impact on student emotional, behavioral, and academic capacities as they return to the classroom after inpatient care (Reback, 2010). However, mental health disorders have a significant economic impact on education support services that schools can provide (Snell et al., 2013). School districts are often forced to reduce school social workers, school counselors, and school psychologists due to financial pressures, especially because these programs are not strongly related to increasing students' standardized test scores (Reback, 2010). In fact, some states do not require districts to employ any elementary school counselors (Reback, 2010).

Researchers from Pittsburgh, Robb et al., (2011), investigated the financial impact of ADHD on school funding. The researchers suggested that the cost of educating ADHD students was higher due to special education utilization, grade retention, and disciplinary actions. Specifically, discipline cost was calculated by the amount of time teachers and administrators spent on each disciplinary incident. Aggregating the costs, the researchers concluded that educating each student costs an annual estimate of $5,007 in additional costs to the educational system. Thus, the authors estimate the incremental lifetime cost of educating the population of ADHD students over 13 years is approximately $174 billion.

Other researchers have also concluded that educating students with mental health is more expensive than those without (Snell et al., 2013). Snell et al., (2013) concluded that educational services cost for students with mental health disorders are approximately 11 times more than

mental health clinical services; children with mental health disorders require additional teachers, paraprofessionals, and support services that schools are unable to provide. However, schools do not have funding to meet these increased cost demands (Guo et al., 2010; Snell et al., 2013). Many students returning to school after hospitalization do not qualify for special education or 504 plan services (White et al., 2017). In addition, caregivers of children with chronic illness returning to school have discussed the importance of schools providing homebound instruction to make effective student transitions between hospitalization and school reintegration (Moore et al., 2009). However, homebound services require an Individualized Education Program (IEP) and are not guaranteed post-discharge (Blizzard et al., 2016; Clemens et al., 2010; White et al., 2017). Many parents of students with mental health disorders that were interviewed did not believe that their child's school has a school psychologist or social worker to help their child during the reintegration process as a result of budget issues (Blizzard et al., 2016).

Cultural Factors

While there is no single accepted definition of the word culture, most definitions suggest that culture includes overarching symbols, interpretations, values, and perspectives (Banks, 2015). Additionally, culture can be viewed as the attitudes and norms held within a specific community (Pescosolido, 2007). Within EST, the macrosystem, includes describes the overarching culture that influences a developing child (Bronfenbrenner, 1979). Stigma is a cultural factor present in all environments, including school, neighborhood, community, and nation. In fact, stigmatization by school staff and peers is one of the challenges that students face upon return to school after psychiatric hospitalization (Preyde et al., 2018; Moses, 2010). As such, this aspect of culture will be the focus of this section.

Stigma can be conceptualized as being comprised of three components: stereotypes, prejudice, and discrimination (Corrigan and Shapiro, 2010). Stereotypes are beliefs that individuals hold about the characteristics of children with mental health disorders (McKeague et al., 2015). Based on stigma scales administered to 1,3,93 adults, young children with mental health issues can be viewed as less trustworthy and intelligent than other students (Pescosolido et al., 2007). Furthermore, prejudice refers to negative feelings or attitudes that people have toward youth with mental health needs (McKeague et al., 2015). Several recent studies present that adults and peers view children with mental health needs negatively because of their stereotype that they are dangerous and unsafe (Bellanca & Pote, 2013; McKeague et al., 2015; Pescosolido et al., 2007). Lastly, according to Corrigan and Shapiro's (2010) description of stigma, discrimination denotes the acting out of these negative feelings. For example, teachers and peers may engage in negative behaviors toward students with mental health disorders (McKeague et al., 2015). Specifically, based on responses to vignettes and implicit attitudes reflected through surveys, teachers and peers express keeping more social distance from students with depression, anxiety, and ADHD (O'Driscoll et al., 2012), illuminating that individuals' negative beliefs impact their behavior. Stigma affects behaviors and thus relationships (McKeague et al., 2015). Scrutinizing stigma allows for greater understanding of behaviors affecting teacher and student relationships during the reintegration process after psychiatric hospitalization.

Teacher-Student Relationships

Youth relationships with teachers impact their sense of wellbeing and belonging in the school environment (Savina et al., 2014). However, teachers very likely stigmatize students with mental health disorders as bad or defiant as teachers suggest that students' externalized behaviors are controllable (Crosby et al., 2015). Some teachers even indicated via mental health behavior

quantitative scales, as well as interviews, that students have mental health needs as a result of bad behavior, rather than recognizing that symptoms are a result of mental health disorders (McLeod et al., 2012).

Teachers utilize punitive consequences such as detention and suspension as they believe that students are intentionally exhibiting defiant behavior and believe that the consequences will correct challenging behavior (Crosby et al., 2015). A study designed by Perry et al., (2007), analyzed the use of punitive punishment for students with mental health issues. Stigma theory, which postulates that people develop perceptions of mental illness from family, experience, peers, media, and the public, grounds the study. In the study, adult participants reviewed validated vignettes of children with depression symptoms. The adults suggested that the children were likely to be violent toward others, citing instances like the Columbine shooting. Participants believed punishment was a way to treat childhood depression. Similarly, Crosby (2015) posited that when students act out in class through defiant behavior, using profanity, and so on, many teachers punish students in hopes of pushing them to behave normally. Furthermore, some teachers believed that punitive punishment might fix mental illness and its manifesting behaviors (Perry, 2009).

While teachers rely on punitive consequences to mitigate disruptive behaviors, punishments may exacerbate behavior problems in classroom settings (Silver et al., 2005). Silver and colleagues (2005) conducted a study of 283 preschool through third-grade children that revealed that teachers who stigmatize and had poor teacher-student relationships fostered the continuation and growth of externalized behaviors. Punitive punishment and lower levels of closeness were associated with an increase in externalized behaviors. The study showed that poor teacher-student relationships did not offer the emotional support necessary for transitioning into

school. On the other hand, supportive, non-stigmatizing teacher behaviors promoted the creation of welcoming classroom environments and positive interactions, including discipline. Relationship quality was reported on the Student-Teacher Relationship Scale. The data reported may be important for students who exhibit initially high levels of externalized behavior at the time of transition.

Likewise, a study by Moses (2010) revealed that half of the adolescent respondents reported being treated differently by school staff. While some mentioned being treated differently in positive ways such as receiving additional help on schoolwork, over one-third noted reported being treated negatively. The researcher stated that some students with mental health disorders believed that educators helped them so that they were not subjected to repeated punishment. However, the study revealed that over one-third of participants reported being treated negatively by school staff. Students reported feeling that teachers underestimated their academic abilities, unfairly blamed them, scrutinized them, or avoided them altogether. Most felt that school staff had determined that they were delinquent. Thus, teachers used stigmatizing instructional and behavioral methods when students reintegrate into the classroom. With that in mind, for students returning to the classroom after psychiatric care, many noted that the school environment did not feel stable, predictable, and reliable or safe (Crosby, 2015, Savina et al., 2014). Moses (2010) suggests that this is particularly troublesome because students who are alienated from teachers receive insufficient academic and behavioral support in the classroom.

Peer Relationships

In addition to teacher-student relationships, the presence of mental health disorders will very likely negatively impact peer relationships. Research confirms that peers tend to keep social distance from children with mental health needs (Bellanca & Pote, 2013; O'Driscoll et al., 2012;

Pescosolido et al., 2007). Students who perceive people with mental health disorders as dangerous are likely to be fearful and try to avoid social contact (Corrigan et al., 2007). Children and adolescents often categorize other students with depression as being violent (Pescosolido, 2007; Pescosolido et al., 2007). In fact, a large-scale study illuminated that adults and adolescents view children with depression and Attention Deficit Hyperactivity Disorder (ADHD) as violent and respondents were willing to use legal force to require children and their families to seek psychiatric hospitalization and treatment (Pescosolido, Fettes, et al., 2007).

Moreover, studies show that peers who perceive children as responsible for their mental health conditions and manifested behaviors often express less compassion toward them (Corrigan et al., 2007; Lorona & Miller-Perrin, 2016). When peers believe that the child is responsible for their aberrant behavior, they are less empathetic during the reintegration process (Savina et al., 2014). As students reject others, they even endorse segregated peer groups within the school (Corrigan et al., 2007; Pescosolido, 2007).

In a study by Bellanca and Pote (2013), children ages seven through 11 years old listened to validated vignettes describing students with various mental health difficulties or disabilities; students also listened to a control vignette. Following, the students completed the Shared Activities Questionnaire and Adjective Checklist to measure cognitive and conative components of positive and negative attributes given to a person. The results revealed that children presented negative attitudes toward students in the vignettes with externalized behaviors. The children felt these behaviors were controllable. Furthermore, the results illuminated that children would want closeness with the "normal" children represented by the control vignette.

With that in mind, it is not uncommon for children with mental health conditions to experience perceived or enacted stigma. Specifically, Moses (2014) found that approximately

70% of study participants perceived that they encountered rejection, devaluation, and restricted friendships following psychiatric hospitalization. Perceived devaluation can include identifying mental health patients as less intelligent or as individuals whose opinions are not to be taken seriously (Link et al., 2001). Along with this, students may experience such actions as name-calling, rumors, and even physical harm directed at them as a result of their condition (Preyde et al., 2018).

As such, peer reactions often concern students. In a study of children with at least one affective or disruptive disorder diagnosis, analysis of semi-structured interviews about perceived stigma revealed that students were more concerned with peer stigma than perceptions of school staff upon return to school (Moses, 2010). According to the researcher, students reported not disclosing mental health needs or treatment to peers out of fear of rejection or loss of friendship (Moses, 2010). Adolescents recognize "the fragility of this social status" (Carpenter-Song, 2009, p. 270).

Furthermore, students endorsed withdrawal as a means of coping with the possibility of rejection and bullying (Link et al., 2001; Preyde et al., 2018). Students may reject meaningful connections with other individuals to avoid rejection or devaluation by peers. Not only that, but a study by Crosby and colleagues, already described in this literature review, found that teachers working with students with mental health disorders found that students may be guarded and distrusting of others as a method of avoidance with peers (Crosby et al., 2015). Disengaging from activities and developing apathy toward school as a coping mechanism for stigma creates distance from others during the reintegration process.

Summary

The relationship between a variety of child, family, teacher, and cultural factors influences reintegration into school and classroom cultures following psychiatric hospitalization. The challenging nature of transitioning to school after hospitalization proves to be overwhelming for students (Clemens et al., 2010, 2011). While a complex problem of practice, improving successfulness of elementary student transition would likely improve a child's academic, behavior, and social accomplishment in the learning environment (Simon & Savina, 2010). Although current literature focuses on adolescents, creating an environment of open communication among stakeholders, creating an individualized re-entry plan, and increasing teacher and peer awareness of mental health symptomology benefits adolescents and young students alike (Blizzard et al., 2016; Clemens et al., 2011; Simon & Savina, 2005). Research illuminates that developing an understanding and awareness of student mental health needs in these ways facilitates a successful school re-reentry process for students at the elementary level (Rothi et al., 2008; Savina et al., 2014)

CHAPTER TWO

Needs Assessment Study

The EST framework presented in chapter one illuminated how child, family, teacher, economic, and cultural factors interact in systems and influence reintegration into school and classroom environments following psychiatric hospitalization. The process of school reintegration requires an understanding of the complex interplay of these factors including the perception of preparedness of the child to be discharged, as well as the school to receive the discharged child (Savina et al., 2014). The current needs assessment examined student transitions following psychiatric hospitalizations in Lake Public Schools, a pseudonym. Elementary students in the district have required hospitalization, necessitating examination of the transition process. According to Institutional Review Board (IRB) guidelines, data for the needs assessment could not be collected from children under 18 years of age, including children with impaired decision-making skills. Therefore, the researcher could not interview students due to privacy issues. However, the researcher did have access to kindergarten through grade five certified teaching staff for data collection. Because of the current contextual focus, the needs assessment study examines elementary teacher beliefs and attitudes, teacher efficacy, and PD in understanding and working with students with mental health needs. Specifically, the purpose for this empirical study was to provide evidence that elementary students struggle to reintegrate into the school and classroom environments after psychiatric hospitalization.

Rationale of Study

Approximately 15% of school-age children are diagnosed with some form of mental, behavioral, or developmental disorder, which includes mood or conduct disorders (Bitsko et al., 2016). These students exhibit externalized or internalized symptoms, including aggression or

depressive behaviors (Clemens et al., 2011). Psychiatric hospitalization is an intensive intervention designed to facilitate stabilization of these symptoms. While mental health services can be delivered in many settings to help ameliorate these symptoms, youth with the most severe symptoms receive inpatient treatment (Grupp-Phelan et al., 2007).

While psychiatric hospitalization has been reserved for youth with acute mental health crisis, who cannot be safely helped in outpatient care (Balkin & Roland, 2007), the number of students with mental health emergencies presenting at hospitals has significantly increased over that past several years (Grupp-Phelan et al., 2007; Chun et al., 2016). In fact, the prevalence of pediatric psychiatric hospitalizations increased by 24% between 2007 and 2014 (Chun et al., 2016). Many of these students require inpatient psychiatric care for symptom stabilization, such as managing suicide ideation or psychosis (Chun et al., 2016). Creating a plan to transition back into the school setting may or may not be part of the hospitalization process because the primary focus is on symptom stabilization and disorder treatment (Savina et al., 2014; Simon & Savina, 2007). Notwithstanding, because of mandatory attendance laws, students return to school shortly post-discharge (Preyde et al., 2018).

Although students transition into the school setting soon after discharge, limited research has examined the reintegration process. Several studies have established that adolescents experience difficulty when transitioning back into the school environment upon discharge (Clemens et al., 2010, 2011; Preyde et al., 2018; Simon & Savina, 2007). The studies reveal that students experience academic, emotional, and social stress that occurs during the transition process (Clemens et al., 2010, 2011; Preyde et al., 2018; Simon & Savina, 2007). Preyde et al., (2018) postulate that school reintegration provokes anxiety, depression, and externalized behaviors, such as aggression, inhibiting student success. While this is true, no study can be

located examining elementary students' experiences with the reintegration process. Therefore, elementary student reintegration following psychiatric hospitalization is an area that demands further research.

Teachers play a significant role in the school environment while interacting with students on a daily basis. Current research suggests that general education teachers often lack efficacy and knowledge in teaching students with mental health disorders (Alisic, 2012; Clemens et al., 2011; Reinke et al., 2011; Walter et al., 2006). Furthermore, elementary teachers report feelings of stress about student acting out behaviors (McLeod et al., 2012; Rossen & Cowan, 2015; Savina et al., 2014). Thus, teacher factors provide an entry point into investigating elementary student school reintegration. Understanding teacher factors such as beliefs and attitudes, teacher efficacy in working with students with mental health needs, and training and PD aims to shed light on how these factors influence reintegration. A mixed methods approach, including a focus group and survey, provides insight into the existence of unsuccessful elementary transition at a suburban school with a focus on teacher factors.

Context of Study

This section provides a comprehensive description of the district context in which the needs assessment was conducted. Describing the district context offers information on the elementary student hospitalization to the extent that is possible. Furthermore, this includes an explanation of teacher backgrounds to offer a better understanding of this factor, which is explored by the empirical study.

District Context

The needs assessment was conducted in a mid-size suburban district located in a Midwestern state. Geographically, the school district covers 94 square miles, encompassing city

limits and eight townships. According to 2017-2018 enrollment data, approximately 2,300 elementary students enrolled from within the district boundaries. Additionally, the school district participated in and accepts enrollment of non-resident students for the schools of choice program. With that in mind, students within the district's Intermediate School District (ISD), as well as non-residents within a contiguous ISD may apply for enrollment. As such, an additional 250 non-resident students from neighboring districts were also enrolled. Students attended six traditional elementary schools and one year-round school. Each of the six traditional elementary schools enrolled approximately 400 students, while the year-round school has the lowest enrollment with approximately 150 students.

Teacher Demographics

This study focused on elementary teachers' beliefs, efficacy, and PD in meeting the needs of students with mental health needs. Therefore, it is essential to consider teacher characteristics. See Table 1 for teacher demographics from each elementary building for the needs assessment. In this context, the district employed approximately 181 elementary teachers. This number accounted for general education, special education, and specialist teachers (e.g., music, art, physical education). According to the local ISD (2017), the district employed six Hispanic, one Asian, and 174 Caucasian elementary teachers. General education teachers worked in a range of levels from Young 5's through fifth grade. A program for gifted and talented fourth and fifth graders was available for students who qualify, as well as two separate Spanish Immersion programs. Moreover, full special education services included resource room teachers, one certified emotional impairment teacher, speech and language pathologists, and academic interventionists. Specifically, the district employed special education teachers certified in learning disabilities (LD), speech and language pathology (SLP), reading intervention (RI), math

intervention (MI), emotional impairment (EI), and autism spectrum disorder (ASD). According to district administration, 88% of the elementary teaching staff were female, and the majority are full-time.

Table 1

Needs Assessment District Teacher Demographics

School	Number of teachers	Race and gender	Grades	Years of experience	Special education services
School 1	25	All Caucasian 19 female 4 male	Young 5's- 5th grade	1-33 years	LD, SLP, RI, MI
School 2	28	2 Hispanic 26 Caucasian 25 female 3 male	Kindergarten-5th Grade & Self-contained emotionally impaired classroom	2-32 years	LD, EI, SLP, RI, MI
School 3	37	3 Hispanic 34 Caucasian 33female 4 male	Young 5's-5th grade, Spanish Immersion	1-22 years	LD, SLP, RI, MI
School 4	37	1 Hispanic 36 Caucasian 31 female 6 male	Young 5's-5th grade	4-31 years	LD, EL, RI, MI, Mental health coordination
School 5	16	16 Caucasian 15 female 1 male	Kindergarten-5th grade	1-30	ASD, LD, RI, MI
School 6	25	1 Hispanic 1 Asian 23 Caucasian 21 female 4 male	Young 5's-5th grade, 4th & 5th gifted and talented	5-31	LD, ESL, SLP, RI, MI
School 7	13	13 Caucasian 12 female 1 male	Kindergarten-eighth grade	2-16	LD/inclusion

Students reintegrating into the classroom following psychiatric hospitalization potentially worked with any numbers of these teachers within the district. Students with mental health needs may receive instruction in the general education setting, special education resource room setting, or self-contained special education placement, depending on their needs and eligibility; psychiatric hospitalization does not guarantee eligibility for special education services (IDEA, 2004). IDEA determines eligibility based on 13 qualifying conditions; students with mental health disorders may qualify for special education services under the other health impairment umbrella, emotional disturbance, or for a specific learning disability (IDEA, 2004).

Research Questions

A mixed-methods needs assessment guided exploration of how teacher beliefs, teacher efficacy of teaching students with mental health disorders, and teacher PD influenced elementary student school reintegration. Three research questions supported the inquiry of these factors.

- What are teacher beliefs and attitudes about students with mental health disorders?
- How effective do teachers perceive themselves to be when teaching students with mental health disorders following psychiatric hospitalization?
- How do teachers perceive the quality of PD in supporting students?

Operationalization of Constructs

Construct operationalization must occur to fully understand indicators and the empirical analysis of the research questions. Teacher beliefs and attitudes were defined as the psychological tendencies and understandings that influence actions and behavior. Teacher efficacy of teaching students with mental health needs was defined as the belief in the capability and skills to organize and accomplish the desired student learning and or behavioral outcomes for students with mental health disorders. Lastly, teacher PD was conceptualized as learning

opportunities aimed at increasing teacher knowledge, skills, or changing beliefs or attitudes that result in a change in instruction, with the goal of improving student learning or behavior. Table 2 provides the construct definition, indicators for measuring the constructs, and offers literature to support the measures.

Table 2

Constructs and Indicators

Construct	Definition	Indicator	Measure
Teacher beliefs and attitudes	Psychological tendencies and understandings that influence action and behavior.	Multidimensional Attitudes Toward Inclusive Education Scale (MATIES)	Avramidis, Bayliss & Burden (2000); MacFarlane & Woodson (2013)
Teacher efficacy of teaching students with mental health needs	Belief in the capability and skill set to organize and accomplish desired student learning or behavioral outcomes for students with mental health disorders.	Teacher Efficacy for Inclusion Practices (TEIP)	Alisic (2012); Buell, Hallam, Gamal-Mccormick, & Scheer (1999); Reinke et al., (2011); Walter, Gouze, & Lim (2006); Tschannen-Moran, Woolfolk Hoy, & Hoy (1998)
Teacher professional development	Learning opportunities aimed at increasing teacher knowledge or skills or changing beliefs and attitudes which result in a change in instruction, with the goal of improving student learning or behavior	Teaching and Learning International Survey (TALIS)	DeSimone, L. (2009); Reinke et al., (2011); Walter et al., (2006)

Method

To answer the three research questions, a convergent parallel mixed method research design informed this needs assessment study. According to Lochmiller and Lester (2017), a convergent parallel mixed method design is one in which the quantitative and qualitative data are collected simultaneously. The methodology, including participants, measures, and data collection, are described in this section.

Participants

The recruitment strategy for both the quantitative and qualitative participants of the study involved direct request. Recruitment for the questionnaire and focus group participation followed IRB guidelines by being conducted either in person or via email. One building principal approved participant recruitment during the final staff meeting of the school year. This specific building has a particularly low response rate of district-provided online surveys in the past; promoting the questionnaire in person was done to promote an increase in response rate. Additionally, district teachers were recruited via their district provided email addresses.

Conducting nonprobability sampling included all elementary school teachers (N=181) within the school district. Teachers were sent an email with an invitation to participate in the student mental health survey. This included general education, special education, and specialist teachers. Invitations were also sent to interventionists, such as reading teachers, speech pathologists, and teaching assistants who held current and elementary-endorsed teaching certificates. Of the 64 survey responses, 46 were considered complete and valid, providing an overall response rate of 25%. Of the participants, 43 (93.48%) were female, while three (6.52%) were male; because of the demographics of teachers employed, it was expected that female respondents would far exceed male respondents. Three respondents (6.52%) were general

education Young 5s teachers, 19 respondents (41.3%) were general education kindergarten through second-grade teachers, while 12 respondents (26.09%) were general education third through fifth-grade teachers. Special education teachers accounted for 13.04% of respondents. The remaining seven responses (13.04%) were provided by a district reading teacher and specialist teachers. While Spanish Immersion, interventionists, and English Language teachers were included in the survey invitation email, they did not respond.

Participants for the semi-structured interview (N=5) were also invited by email. Emails for the focus group were only sent to teachers who have experience working with students transitioning to the classroom setting following psychiatric hospitalization. Participants were recognized and recommended by elementary school principals. While five teachers were invited, three chose to participate in the focus group. Each teacher represented the same elementary building, and all participants were female. One participant had a special education emotional impairment endorsement; however, she had never taught in a special education classroom. For all three teachers, this was the first experience they have had with a student transitioning to school post-discharge. Table 3 presents focus group participants' demographic information.

Table 3

Focus Group Interviewee Demographics

	Transition teachers *n (%)*
Definition/Criteria	Elementary teachers who taught a student who transitioned into the classroom after psychiatric hospitalization
Number of Teachers Invited	5 (100)
Number of Participants	3 (60)

	Transition teachers *n (%)*
Grade Level	2 (66.7)
Grade 1	1 (33.3)
Grade 4	
Years of Teaching Experience	
Seven Years	1 (33.3)
Thirteen Years	1 (33.3)
Twenty-Seven Years	1 (33.3)
Teaching Degree/Experience	
General Education	3 (100)
Special Education	0 (0)

As the researcher was an elementary educator, the participants of the survey and focus group were colleagues within the school and across the district. Having equivalent positions within the district indicates there was no direct authority over participants, mitigating coercion. Therefore, it was not necessary to have a contact person who did not have direct authority aid in the recruitment of participants. To further avoid undue influence, participants were required to give consent before completing the survey and taking part in the focus group. In both the survey and focus group, participants were told that choosing not to participate has no implications for their employment and evaluation of their job performance. Additionally, consent clearly stated that participants might choose to drop out of the study at any time. To consent on the questionnaire, participants answered an online consent statement before continuing, while focus group participants signed a consent form. The researcher collected and retained consent information.

Measures

Because the needs assessment study included a mixed methods approach, it required two different instruments. The quantitative portion of the study utilized the student mental health survey, while the qualitative relied on a semi-structured focus group interview. Each instrument is described in detail below.

Quantitative Instrument

The quantitative questionnaire collected data regarding three specific constructs: teacher beliefs and attitudes about student mental health, teacher efficacy in teaching students with mental health needs, and teacher PD about student mental health. Three pre-existing scales informed the 52-item survey (Appendix A). The researcher obtained permission from each author to use pre-existing scales for the needs assessment. The subsection from the Multidimensional Attitudes Toward Inclusion Education Scale (MATIES; Mahat, 2008) created the 16-item teacher beliefs and attitudes section. The MATIES subsection asked respondents to consider their beliefs about schooling placements for students with mental health disorders. The items also asked respondents to consider their willingness to work with students with mental health needs, as well as their frustration level working with these students. Mahat (2008) notes that the theory of planned behavior, which postulates that the formation of intention is influenced by attitudes toward a behavior, informs the scale. The subscale provided evidence of construct and criterion validity (Mahat, 2008). Additionally, the Cronbach's alpha for the subscale was .91.

Current literature shows that many teachers report lacking efficacy in working with children with mental health issues, specifically managing externalized, or acting out, behaviors (Alisic, 2011; Clemens et al., 2011; Reinke et al., 2011; Walter et al., 2006). The Teacher Efficacy for Inclusive Practices (TEIP; Sharma et al., 2012) comprised the teacher efficacy of

teaching students with mental health needs section of the survey. The survey included only the "efficacy in managing behavior subsection" of the scale as appropriate for the needs assessment purposes. The efficacy in managing behavior subscale showed good internal consistency. This section asked teachers to answer questions about their efficacy in addressing student mental health needs, particularly behavior management, in the classroom. The items also asked participants to consider their self-efficacy in recognizing and responding to students in distress. The teacher self-efficacy subsection included 14 items.

Along with that, the Teaching and Learning International Survey (TALIS) PD subsection (Organization of Economic Co-Operation and Development, 2008) comprised the final section of the questionnaire. TALIS is an international survey used by the Organization of Economic Co-Operation and Development (OECD) to collect data about teacher perspectives of learning environments. The OECD deemed the survey valid and reliable. These subsection items asked respondents about the types of PD opportunities they have engaged in the past 18-months and how positively these impacted working with students with mental health disorders. Moreover, these items asked what information respondents still needed in order to work effectively with students' mental health disorders.

Constructing the survey through Qualtrics allowed for multiple modes of responses, including multiple choice, textbox, and Likert-type responses. The first five items asked participants to provide background demographic information on educational attainment, teaching status, teaching experience, and subjects taught. Forty-three items asked participants to indicate beliefs and attitudes towards working with students with mental health issues, efficacy in meeting needs of students with mental health needs, and amount of PD they have received regarding understanding student mental health needs. Two questions asked participants to

indicate how much PD they have received in the past 18 months regarding student mental health, as well as how many hours of PD in the past 18 months they have received regarding student mental health during school hours.

While the questionnaire described broad information about elementary teacher background and experience with teaching students with mental health disorders, it did not specifically address the essential component of the teacher role in school reintegration following psychiatric hospitalization. Furthermore, the complex nature of student reintegration into the school setting required a deep understanding of how teachers derive meaning from the context (Lochmiller & Lester, 2017). Therefore, the researcher conducted a focus group interview.

Qualitative Instrument

A semi-structured focus group interview comprised the qualitative instrument. The interview questions (See Appendix B) focused on specifically addressing teacher perspectives of the student reintegration process. Current literature suggests that teachers express frustration when being responsible for student social and emotional needs (Alisic, 2012; Reinke et al., 2011). Therefore, the interview consisted of questions asking about teacher roles during the transition process; the questions also asked about what roles other stakeholders, such as principals, play in the process.

Likewise, the interview asked teachers to consider the types of supports they need during the transition process. Current literature illuminates that teachers often feel unprepared to meet the academic and behavioral needs of students with mental health disorders (Buell et al., 1999; Clemens et al., 2011; Simon & Savina, 2010; Reinke et al., 2011). This question builds on the literature by asking teachers what they need, such as ancillary staff or training, to be successful. Along with that, teachers share information they believe should be provided about a student's

mental health disorder before a student returns to school and how that facilitates preparation for return.

The focus group followed a semi-structured procedure because a predetermined set of questions guided the interview. However, the protocol encouraged open-ended, clarifying questions conversationally. It also allowed for unexpected understandings to emerge (Lochmiller & Lester, 2017). Some questions were very general (e.g., talk about how students transition into school after psychiatric hospitalization), while some sought to address teacher beliefs, efficacy, and PD specifically related to student reintegration (e.g., discuss the kinds of support you would like to have during this process.).

Procedure

Data Collection

One week before sending out the survey link, each building principal was notified about the study via email or during a phone conversation. An introductory email explaining the survey, purpose, and benefits of the survey was sent to all elementary teachers via their district provided email. The survey window ran for three weeks, during the last week of school. Three weeks provided teachers ample time to complete the survey. Two reminder emails were sent throughout that time. The survey data were emailed, collected, and exported through a secure Qualtrics account.

According to convergent parallel mixed methods design, focus groups occur simultaneously. With that in mind, the focus group occurred during the last week of school. Teachers who had experience with student transition into the classroom participated in the focus group.

The semi-structured focus group took place in the natural school setting after school hours. Specifically, the interview occurred in the classroom of one participant. A kidney-shaped table was used to create the atmosphere of a small group meeting. Before the commencement of the interview, the researcher verbally explained the purpose of the focus group, as well as notified the teachers of their rights of participation. The participants were assured that their individual responses would be kept confidential and that honest perspectives would enhance the research being conducted. Participants were also asked to review and sign a research consent form. According to IRB guidelines, the focus group interview time was limited to 45 minutes to one hour. The focus group was within these set parameters, lasting approximately 43 minutes. Responses were recorded and transcribed verbatim.

Data Analysis

The researcher utilized Statistical Package for Social Sciences (SPSS) to analyze the quantitative survey. Descriptive statistics, including frequency, mean, and standard deviation (SD) were computed using SPSS for participants' responses to the student mental health survey.

An inductive approach (Glaser & Strauss, 1967) guided the analysis of the qualitative focus group data. Inductive coding differs from a priori coding in that it does not require predetermined codes that are directly linked to the literature synthesis informing the needs assessment (Lochmiller & Lester, 2017). Rather, inductive coding allowed for themes related to the teachers' experiences with student reintegration in the classroom to emerge.

To determine themes, the researcher first examined the data holistically and recorded overall impressions of teacher responses (Glaser & Strauss, 1967). In addition, responses were divided into chunks of data, including phrases used by the participants. Next, the researcher coded the data line-by-line to create categories. Categories were combined into themes related to

the research questions. This process was completed a few times until a clear exhaustion, or saturation, of patterns provided a clear understanding of the data. Lochmiller and Lester (2017) note that when carrying out qualitative analysis it is essential to reach the point of saturation; saturation can be defined in analysis when "no new information and understanding is generated" (p. 178).

Findings

The findings for the mental health survey will describe teacher beliefs and attitudes about student mental health, teacher efficacy in working with students with mental health, and teacher training in meeting student mental health needs. The qualitative focus group findings will focus specifically on teacher experiences from the student transition process.

Quantitative Findings

Teacher Beliefs and Attitudes

The survey results indicated that participants expressed positive attitudes toward working with students with mental health disorders. In fact, 84.7% of respondents reported that they believed inclusion promotes academic and social progression of students. With that in mind, 6.5% of respondents either agreed or strongly agreed that students with mental health disorders should attend specialty schools specifically for students with psychiatric disorders. Only 2.2% of teachers expressed that students with mental health disorders should attend specialty school to avoid rejection in a regular school. However, the survey illuminated mixed results regarding frustration level with students in the classroom; 37.8% of teachers somewhat agreed (28.9%), agreed (6.7%), or strongly agreed (2.2%) that they get irritated when they do not understand the needs of students with mental health disorders.

Respondents expressed that they would work to participate in classroom activities (88.9% agreed or strongly agreed), modify classroom space (86.6%) agreed or strongly agreed), and adapt communication techniques so that students with behavioral needs can be successfully included in classroom activities (91.1% agreed or strongly agreed). Table 4 represents teacher beliefs and attitudes findings.

Table 4

Teacher Beliefs and Attitudes About Students with Mental Health Needs

	n (%)							
	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly Agree	Mean	Standard Deviation
Inclusion beliefs								
Promote social progression	0 (0)	0 (0)	3 (6.5)	4 (8.7)	10 (21.7)	29 (63)	5.41	.909
Facilitates appropriate behavior	0 (0)	5 (10.9)	4 (8.7)	11 (23.9)	18 (39.1)	8 (17.4)	4.43	1.205
Students with disorders should be in specialty schools	5 (10.9)	12 (26.1)	15 (32.6)	11 (23.9)	2 (4.3)	1 (2.2)	2.91	1.151
Frustration with students								
Frustrated communicating with students with disorders	4 (8.9)	16 (35.6)	9 (20)	10 (22.2)	5 (11.1)	1 (2.2)	2.98	1.270
Frustrated when students with disorders can't keep up	12 (26.7)	22 (48.9)	5 (11.1)	6 (13.3)	0 (0)	0 (0)	2.11	.959
Upset when I don't understand psychiatric needs	5 (11.1)	17 (37.8)	6 (13.3)	13 (28.9)	3 (6.7)	1 (2.2)	2.89	1.265
Upset with students with psychiatric disorders in my class	10 (22.7)	18 (40.9)	4 (9.1)	12 (27.3)	0 (0)	0 (0)	1.89	1.049
Frustrated when I have to adapt curriculum	25 (55.6)	14 (31.1)	5 (10.9)	1 (2.2)	0 (0)	0 (0)	1.60	.780
Willingness to help students								
Help students with disorders participate in social activities	0 (0)	1 (2.2)	1 (2.2)	3 (6.7)	15 (33.3)	25 (55.6)	5.38	.886

	n (%)							
	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard Deviation
Adapt curriculum	0 (0)	1 (2.2)	0 (0)	4 (8.9)	17 (37.8)	23 (51.1)	5.36	.830
Physically include students	0 (0)	1 (2.2)	0 (0)	1 (2.2)	18 (40)	25 (55.6)	5.47	.757
Modify physical environment	0 (0)	0 (0)	1 (2.2)	5 (11.1)	20 (44.4)	19 (42.2)	5.27	.751
Adapt communication	0 (0)	0 (0)	2 (4.4)	2 (4.4)	22 (48.9)	19 (42.2)	5.29	.757
Adapt assessments	0 (0)	0 (0)	3 (6.7)	4 (8.9)	19 (42.2)	19 (42.2)	5.20	.869

Teacher Efficacy

The mental health survey findings illuminated variability in teacher self-efficacy when working with students with mental health disorders in classroom settings. The survey revealed that many teachers felt efficacious in dealing with students in distress. Specifically, 51.1% of teachers responded that they agree or strongly agree that they can recognize when a student is in emotional distress. Similarly, 40 teachers (88.9%) revealed that they could intervene effectively when a student is in emotional distress.

While 75.5% of teachers reported that they felt confident in being able to get students to follow classroom rules, only seven respondents (15.6%) agreed they felt confident about their ability to deal with students who are physically aggressive. One respondent (2.2%) chose strongly agree in to feeling confident in dealing with students who are physically aggressive. Thirteen (28.9%) teachers agreed that they could calm a student who is exhibiting acting out or harmful behaviors; one (2.2%) teacher strongly agreed to being able to calm a student exhibiting harmful behaviors.

The survey also showed low teacher self-efficacy in discussing policies regarding students with mental health disorders. Few teachers noted that they felt confident informing

others about laws and policies related to the inclusion of students with mental health needs; three (6.7%) chose strongly disagree, 16 (35.6%) chose disagree, seven (15.65%) chose somewhat disagree. Table 5 summarizes the results of the teacher efficacy subsection of the student mental health teacher survey.

Table 5

Teacher Self-Efficacy Findings

	n (%)							
	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly Agree	Mean	Standard Deviation
Student behaviors								
Prevent disruptive behaviors	4 (8.9)	3 (6.7)	4 (8.9)	20 (44.4)	13 (28.9)	1 (2.2)	3.84	1.242
Calm harmful behaviors	1 (2.2)	2 (4.4)	6 (13.3)	22 (48.9)	13 (28.9)	1 (2.2)	4.04	.952
Aggressive behavior	5 (11.1)	10 (22.2)	10 (22.2)	12 (26.7)	7 (15.6)	1 (2.2)	3.20	1.324
Make expectations clear	4 (8.9)	16 (35.6)	9 (20)	10 (22.2)	5 (11.1)	1 (2.2)	5.09	1.019
Get children to follow rules	0 (0)	1 (2.2)	3 (6.7)	7 (15.6)	29 (64.4)	5 (11.1)	4.76	.830
Notice students in distress	0 (0)	5 (11.1)	0 (0)	17 (37.8)	18 (40)	5 (11.1)	4.40	1.074
Intervene when in distress	0 (0)	2 (4.4)	3 (6.7)	21 (46.7)	15 (33.3)	4 (8.9)	4.36	.908
Helping families								
Get families involved	0 (0)	0 (0)	4 (8.9)	21 (46.7)	17 (37.8)	3 (6.7)	5.38	.886
Assist families in helping children in school	0 (0)	1 (2.2)	1 (2.2)	8 (17.8)	25 (55.6)	10 (22.2)	4.93	.837
Getting parents involved in school	0 (0)	0 (0)	4 (8.9)	21 (46.7)	17 (37.8)	3 (6.7)	4.42	.753
Make families feel comfortable coming to school	0 (0)	0 (0)	1 (2.2)	10 (22.2)	23 (51.5)	11 (24.4)	4.98	.753

	n (%)							
	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation
School Policy								
Collaborate with others	0 (0)	0 (0)	8 (4.4)	8 (17.8)	16 (35.6)	19 (42.2)	5.16	.878
Adapt assessments	2 (4.4)	8 (17.8)	9 (20)	15 (33.3)	6 (13.3)	5 (11.1)	3.67	1.348
Inform others about laws	3 (6.7)	16 (35.6)	7 (15.6)	14 (31.1)	4 (8.9)	1 (2.2)	3.07	1.232

Teacher Preparation

The mental health survey illuminated PD needs among teachers within the district. Teachers self-reported the need for mental health PD, particularly for responding to externalized behaviors. See Table 6. Forty (93%) respondents commented that they needed more information on instructional strategies to improve their ability to work with students with mental health needs. Similarly, 40.9% of teachers agreed that they needed more information on understanding how different mental health disorders affect learning and cognition, while 45.5% strongly agreed they needed more information.

The survey also showed that 77.2% of respondents either agreed or strongly agreed that they needed more training in being able to recognize various mental health disorder symptoms. In considering behavior, 97.7% of respondents noted that they felt that they needed more training in classroom management skills, particularly in acting out behaviors, to be more effective in working with students with mental health disorders. This is consistent with the low self-efficacy scores mentioned above. With that in mind, 87.8% of teachers either agreed or strongly agreed that they needed more training in assessing and referring students for mental health services.

Table 6

Teacher Needs for Professional Development Findings

	n (%)							
	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly Agree	Mean	Standard Deviation
Instructional strategies for students with mental health needs	0 (0)	1 (2.3)	2 (4.7)	8 (18.6)	16 (37.2)	16 (37.2)	5.02	.988
Assessing and referring students for mental health services	0 (0)	1 (2.4)	2 (4.9)	2 (4.9	20 (48.8)	16 (39)	5.17	.919
Classroom management	0 (0)	0 (0)	1 (2.3)	11 (25)	1 (34.1)	17 (38.6)	5.09	.858
Understanding symptoms of mental health disorders	0 (0)	0 (0)	2 (4.5)	8 (18.2)	17 (38.6)	17 (38.6)	5.11	.868
How disorders affect the brain	4 (8.9)	1 (2.3)	1 (2.3)	6 (13.6)	18 (40.9)	18 (40.9)	5.16	.914
How disorders affect learning and cognition	1 (2.3)	1 (2.3)	0 (0)	4 (9.1)	18 (40.9)	20 (45.5)	5.20	1.047

Qualitative Findings

Stakeholder Roles

The focus group began with the researcher asking the participants to consider the roles that stakeholders, including teachers, administrators, and parents, play during the transition process. The teachers reported that administrators place students into classrooms based on their

discretion, but the teacher role can be unclear. Participant Two noted that "it's very gray for who's responsible for what. What am I responsible for? What are you responsible for doing?"

Participants expressed inconsistency in communication and low self-efficacy throughout the transition process. One participant noted that her student qualified for special education Emotional Impaired (EI) label; confusion in boundaries between the EI program and general education classroom led to a lack of confidence in what her role was in the process. An additional participant commented that the lack of communication created undefined roles and responsibilities. One participant agreed, saying

> I don't feel that there is a clear picture of how the transition is managed. There is not a clear protocol of how these children with issues will transition into a traditional classroom during this transitional period. It's not clear (Participant Two).

While two of the three teachers stated that they believe their primary role as an elementary teacher should be providing academic instruction, they commented on the difficulty in providing instruction and meeting the needs of students in the transition process. As such, all three teachers noted that academics became secondary and that behavior management took precedence, especially when working with students with disruptive and aggressive behaviors. Furthermore, the participants noted that school faculty in the building have a role in assisting with behaviors, such as calling for help, blocking doorways, and restraining. All three participants commented that principal absence from the building created variability in administration assistance with behavioral issues.

Two participants described parent stakeholder involvement in the planning and decision-making process as limited. The teachers suggested that parents did not communicate with the

school about current student needs or provide a release to allow the teachers the opportunity to speak with a mental health provider about diagnosis or treatment.

Student and Teacher Support

When asked about barriers to student success during the transition process, all participants noted that student behaviors prevent successful reintegration. One participant commented that "he struggled with violence. He was violent toward himself, violent toward others. He eventually started using the bathroom in the room" (Participant Three). Another teacher agreed by saying, "many times he explodes and tries to escape when I'm alone with 24 kids, and I have to go after him" (Participant One).

With student behaviors as a barrier to reintegration, participants expressed the need for student and teacher supports. All of the participants reported that students did not receive consistent social support in the classroom; two of the three teachers noted that their students' social work services were decreased in order to make up academic skills that were missed while out of the classroom. All participants did suggest that the students participated in an adaptive physical education (PE) class. The PE class was offered twice a month where students were paired with a peer to work on friendship skills within a PE setting. Furthermore, students returning to the classroom with externalized behaviors, including acting out or harmful behaviors, stayed in the regular classroom with just the classroom teacher for support. Two participants recalled that their students who exhibit aggressive behaviors would remain in the classroom on "tough" days until they needed to be restrained and eventually sent home.

With this in mind, teachers also expressed that they experienced conflict in receiving support or training to meet student needs. Teachers reported that they were expected to utilize behavior

plans including point sheets and prize boxes, as well as engage in behavior meetings. Participant One commented that,

> Even after 105 days, I still had nothing new for him. The behavior specialist observed him. Everyone observed him. But I had nothing. I had a point sheet. But he never got placed in special ed. When he melted down the whole school knew it. You would hear him all the way through the halls. I don't believe it should take 105 days.

To extrapolate, all of the participants discussed that they do not know what to do with students in the transition process or how to handle disruptive or aggressive behaviors; however, all participants agreed the solutions provided are ineffective in mitigating externalized behaviors.

Teachers suggested that they needed additional ancillary support, including social work, to physically help manage the transition process and student behaviors. Without management support, the participants agreed that academic instruction came to a stop for the rest of the class. All of the participants concluded that even with adequate training and behavioral preparation they would still need "extra hands" in the classroom.

Knowledge and Training

In asking how the classroom environment impacts the school transition process, all three participants agreed that having a student with a psychiatric disorder transitioning into the classroom was not a choice and that it can make days difficult. However, all three agreed they were willing to work with these students. Additionally, all of the participants reported that they felt that administrators should consider teachers' knowledge, confidence, and willingness level before placing a student with psychiatric needs. Participants expressed that teachers within the district are not trained to deal with severe needs, which can be difficult for students and teachers. In recounting an experience with another teacher, one participant explained,

> There was a student who returned who was very volatile and the teacher just really didn't know how to not trigger this child. So, a lot of times things were escalated because the teacher just didn't know better (Participant Three).

To further the conversation, another participant added "she was not trained for this. She wasn't confident. People who aren't trained for this, it's not a good fit" (Participant Two). All agreed that training affects knowledge and confidence in working with students with mental health issues. Additionally, participants suggested that training is also essential because of the other students in the classroom. Two of the three teachers recommended needed training to keep other students safe.

Information Access

Participants all agreed that it would be helpful to know about student diagnosis, treatment, and history when they return to the classroom. To connect with the student, two participants suggested that they would want to know more about what the students were interested in to engage in conversations and build relationships. One teacher expressed the need to know about history in order to know about behavioral triggers in the classroom.

As mentioned briefly earlier, one prominent area of concern was lack of communication with parents and medical staff. Two participants revealed that they had not been asked to provide input or complete questionnaires for clinicians before or after hospitalization for student mental health symptoms. Likewise, all of the participants expressed frustration that they are not able to speak with medical staff without parents' release. One teacher felt that the parent and counselor acted as if they did not want her input on the student's symptoms in the school setting. The other participants agreed that parents seemed nervous to share information.

Participants also expressed concern for parents' lack of access to mental health resources available and their possible ability to advocate for their children. In fact, one participant's perspective noted that it seemed "parents have no idea what they are doing." Two teachers discussed how they felt parents are often unable to relay information from psychological testing to teachers because they are unsure of what it means. In addition, all participants commented that they believed the district offers limited resources for parents of students with mental health disorders. The teachers discussed how administrators could possibly add links to mental health resources to the district website for parents.

Mental Health Beliefs

Throughout the interview process, focus group participants mentioned the need for support and training in meeting the needs of student externalized behaviors during the transition process. The interview also uncovered teacher beliefs about student behaviors, including that they are "attention-seeking" (Participant One). All of the participants concurred that to some extent the students used behaviors to "play the game." For instance, one teacher explained that a student "knew how to work the system to get what he wanted" (Participant Two).

The focus group participants also shared beliefs about how parents and caregivers contribute to student mental health needs and behavioral issues. For instance, the teachers discussed that family interaction contributed to emotional problems. Participant Two shared that "I feel like there's more kids that have mental illness or emotional problems because of their parents or the way they are brought up or the environment they are brought up in." Participant One agreed that "lack of attention at home is huge."

Additionally, the participants implied that parents of students reintegrating into the school setting are not involved in the transition process. Specifically, two of the three interviewees discussed limited parental investment in process. One participant suggested,

> My parent doesn't care. She's out of the picture. The wellbeing of her child is not on her radar. She is more worried about herself and the wellbeing of her younger children that she likes better (Participant Three)

To contrast, the third participant suggested schools should build a partnership with parents. This teacher commented that, rather than not caring, parents might not know how to advocate for their children or know what services are available in the school district.

Discussion

Combined, the findings of the survey and focus group provide evidence of unsuccessful student reintegration after psychiatric hospitalization within the professional context. Furthermore, the empirical study affords insight into understanding teacher factors in the problem of practice. The section offers a discussion of the research questions.

Research Question One: What are teacher beliefs and attitudes about students with mental health disorders?

Teachers who responded to the mental health survey generally self-reported positive attitudes toward students with mental health needs. Specifically, 80.4% of teachers expressed that they somewhat agreed (23.9%), agreed (39.1%), or strongly agreed (17.4%) that inclusion facilitates socially appropriate behavior amongst all students. The following results from the focus group seem to contradict that belief, as they suggest that students with mental health have a negative impact on in the classroom. Specifically, a deeper investigation into the focus group suggested that teachers of transitioning students noticed that students' disruptive or aggressive behavior had

a negative impact on classmates' social and academic growth. Teachers commented that student behavior impeded academic instruction, which is supposed to be their primary role in the classroom. While the results of the focus group contradict the survey, the focus group participants were representative of the survey population, although they have the added experience of having as student transition into the classroom after hospitalization. These findings support Alisic's (2012) observation that elementary teachers felt that other students feared students with externalized behaviors, as well as teachers finding it difficult to meet the needs of the student with a mental health need while continuing to care for the other students in the class. The findings are also consistent with Alisic (2012) and Reinke et al., (2011) that show that teachers believe their main role should be to provide academic instruction and that students with mental health disorders hinder that role. It seems that focus group participants believe their role as an instructor is limited partly because they cannot help the other students in the class because the transitioning students' behavior required a significant amount of their time during the school day. The teachers also mentioned that this extreme student behavior seems to be attention-seeking and intentionally isolating from peers, which was a habit that needed to be broken upon return to school. This is consistent with Savina et al., (2014) which proposes that teachers may see hospital behaviors as different and unacceptable from school behavior, necessitating remediation.

Regarding teacher willingness to work with students with mental health disorders, both survey respondents and focus group participants expressed willingness to include students in classroom activities and provide necessary supports. To contrast this, Graham et al., (2011) found that teachers who lacked self-efficacy were often unwilling to work with students with psychiatric disorders. Furthermore, teachers with transitioning students seemed to express stronger opinions

about these issues than survey respondents. For instance, while 40% of survey respondents agreed that they would be willing to physically include students with mental health needs in the regular classroom with necessary supports including aides or paraprofessionals, all of the focus group teachers communicated that they would not only be willing to work with paraprofessionals, but that ancillary support in the classroom was essential for working with students who are transitioning after hospitalization.

Research Question Two: How effective do teachers perceive themselves to be when teaching students with mental health disorders?

The focus group provided evidence that teachers lack self-efficacy in managing disruptive and aggressive behaviors of students transitioning into the classroom. In fact, participants explicitly noted not knowing how to handle disruptive students. One focus group participant also noted not being able to recognize disorders with internalized symptoms. The survey results reflected similar low self-efficacy rates when working with students with mental health disorders; the results mostly indicated low self-efficacy when dealing with students with externalized behaviors. For instance, few respondents agree (28.9%) or strongly agree (2.2%) that they believe they are able to calm a child who is exhibiting acting out or harmful behaviors. Similarly, few teachers agree (15.6%) or strongly agree (2.2%) that they are confident in dealing with a child who is physically aggressive.

Focus group participants commented numerous times throughout the interview that they lacked training, a clearly defined role throughout the process, and district behavioral support. This is consistent with the Reinke et al., (2011) study which found that teachers lacked efficacy in dealing with aggressive and acting out behaviors, suggesting they did not have classroom management strategies to meet these needs. Likewise, Frauenholtz, Mendenhall, and Moon's

(2017) study concluded that teachers often lack self-efficacy in managing students with challenging behaviors as a result of lack of training and PD opportunities. The focus group teachers also suggested that their organization conveyed limited knowledge about mental health, leaving them feeling frustrated and unconfident with the transition process.

Research Question Three: How do teachers perceive the quality of professional development in supporting students?

As revealed in research question two, teacher training provides opportunities to increase knowledge and teacher efficacy. Already mentioned, focus group participants noted that they lacked the training to meet students' behavioral needs. One teacher commented that she took a trauma-informed class at a local church outside of school hours to increase her knowledge about childhood mental health; she found the workshop helpful in working with her student. Similar to the focus group participants, many survey respondents also did not engage in formal or informal PD during the past 18 months. Of the training that they did participant in, teachers reported mixed outcomes. For instance, 50% of teachers disagree (30%) or strongly disagree (20%) that attending conferences positively impacted how they meet the needs of students with mental health disorders in the classroom; additionally, 26 of the 46 respondents reported not attending conferences. Moreover, 43.8% of respondents agreed that mentoring was an effective form of PD; however, 30 of the 46 respondents did not engage in this form of training. A study by Rothi et al., (2008) explained that, while teachers recognize the need for PD they often do not participate because of after-hour time constraints. The survey results seem to show that many have limited time availability.

While teachers showed limited PD involvement, many reported continued PD needs. Not surprisingly, one area of expressed need was classroom management; 72.7% of respondents

either agreed (34.1%) or strongly agreed (38.6%) that they needed PD in classroom management strategies. Furthermore, many teachers revealed that they need PD to recognize symptoms associated with various mental health disorders. Walter et al., (2006) suggested that limited PD and knowledge does prevent teachers from being able to recognize symptoms associated with mental health disorders. A primary problem caused by this is that it prevents teachers from making appropriate referrals. The focus group participants felt that even with PD that they still needed additional communication with parents and medical staff about diagnosis, medication, and history to help with the transition process. Simon and Savina (2010) postulate that school staff needs student information to create goals and expectations for the transition process.

Limitations

Multiple factors limited the findings of this needs assessment. First, it is important to consider the limited population for both the survey and focus group interviews. One possible explanation is that the survey and interview occurred during the last few weeks of the school year, a busy time period for elementary teachers. Another possible reason is the controversial topic and lack of comfort discussing the topic. The survey had a limited response rate of 25%. Regarding the focus group interview, only three teachers of the five-invited chose to participate. Additionally, all three participants currently teach in the same elementary building, only offering perspectives from that environment; the two other teachers come from two separate elementary settings within the district. Furthermore, two of the three participants offered perspectives of the same grade level (grade one), limiting viewpoints of teachers of multiple grade-levels. The survey relied on teacher self-reported data. All future studies should explore ways of triangulating data. Lochmiller & Lester (2017) explain that triangulating data is a way of ensuring validity by

establishing evidence across numerous sources of data. In this specific case, multiple focus groups, interviews, and possibly observations seem appropriate.

Implications

The findings of this study reveal that although many teachers expressed willingness to promote student mental health in elementary schools, they reported low self-efficacy in recognizing and responding to student mental health symptoms. Study participants expressed that they are not adequately prepared to meet student mental health needs in the classroom. Ashton and Webb (1986) suggest that if teachers do not believe they can perform specific tasks, such as manage behaviors, they will not persist in working with these students. The survey and focus group pinpoint a clear need for connecting PD to specific challenges, including managing disruptive and harmful behaviors, to improve teacher efficacy during the reintegration process. Focus group participants reported that the student reintegration process typically does not occur systematically; however, effective dissemination of teacher PD should be systematic, include consultation, and evaluate outcomes (Reinke et al., 2011).

Barriers to school reintegration also included the quality of teacher PD Teachers felt that such PD formats as workshops and conferences were not effective in helping them improve their skills in meeting student mental health needs. Tschannen-Moran and McMaster (2009) outline effective PD formats. The authors suggest that successful teacher PD includes information, modeling, practice, and coaching (Tschannen-Moran & McMaster, 2009). These may be important components to consider when training teachers to work with students returning to school after psychiatric hospitalization.

Conclusion

Findings from this convergent parallel mixed methods study evidenced that while elementary teachers are willing to work with students with psychiatric disorders, they lack self-efficacy, as well as resources and supports, to do so. This is especially true when teaching students with externalized behaviors; teachers lack-efficacy in managing acting out, disruptive, and aggressive behaviors. Furthermore, the study provided insight into teachers' need for training and PD opportunities about childhood mental health disorders. Teachers specifically reported the additional need to be able to recognize disorder symptoms, as well as manage behaviors. Teachers working with elementary students reintegrating into the classroom setting after psychiatric hospitalization noted that PD should be provided by the school district and offer timely, relevant strategies that can be implemented immediately. Moreover, teachers of students in the transition process felt that they should have a person to contact with follow-up questions and concerns, if necessary.

As demonstrated in these teachers' responses and conversations, the teachers' need for support with students with mental health disorders in the classroom is substantial. Many teachers felt unprepared to meet children's needs. Chapter three explores the current literature to begin the intervention design. The intervention implementation will address teacher beliefs, teacher self-efficacy, and teacher PD in working with students with mental health needs to improve student success when reintegrating into the school and classroom setting after psychiatric hospitalization.

CHAPTER THREE

Intervention Literature Review

Elementary teachers are often well situated to help recognize and respond to unmet childhood mental health needs because of their sustained contact with children (Long et al., 2018; Rothi et al., 2008). Therefore, teachers are considered front-line professionals who are in a position to recognize and respond to student mental health crises, including externalized and internalized behaviors (Rothi et al., 2008). Elementary teachers are typically familiar with typical and atypical child development, behavior, and learning; however, many indicate that they are not prepared to address the classroom needs of students with mental health disorders (Pereira et al., 2015) and have limited PD in recognizing and responding to student mental health issues (Reinke et al., 2011; Ringeisen et al., 2003). Chapter one identified insufficient teacher PD as a salient challenge in influencing mental health knowledge and self-efficacy. To support students reintegrating into the classroom setting after psychiatric hospitalization, current research indicates that teachers need PD in disorder symptomology, classroom strategies to help students in distress, and referring students for school services.

Chapter two presented the findings analyzed from the needs assessment, showing that elementary teachers in a suburban Midwestern district reported they lacked PD, and thus, knowledge and self-efficacy to work with students with mental health disorders transitioning into the classroom following psychiatric hospitalization. Participant responses illuminated PD needs. For example, elementary teachers reported lacking self-efficacy in managing externalized behaviors of students with mental health disorders. Only one of the 46 participants indicated that they felt efficacious in dealing with students with harmful behaviors, yet, many did not engage in formal mental health PD during the previous 18 months, often due to time constraints. The

teachers reported that PD options were available after school hours or on weekends when they had personal obligations. Likewise, 72.6% of respondents (N=18) expressed that they desired PD surrounding student mental health needs, particularly in behavioral support. Also, 77.2% (N=24) of respondents reported needing additional help in being able to recognize mental health disorder symptoms. However, they suggested that one-time conferences and workshops did not positively impact how they met student mental health needs in classroom settings. Teachers' report of the ineffectiveness of one-time conferences is corroborated by current research on PD (see, e.g., Darling-Hammond & Richardson, 2009). The results of the needs assessment indicate that teachers need PD in recognizing mental health disorder symptoms, classroom strategies in responding to symptoms, and cultural awareness to begin to support students in the classroom setting.

This chapter investigates the literature on elements of quality PD that are most effective in helping increase teachers' knowledge and self-efficacy when working with students with mental health needs. Therefore, to support elementary teachers navigating the reintegration process, this chapter examines current literature related to PD interventions for elementary teachers working with students. Specifically, this review explores intervention research related to providing adequate teacher support in student mental health needs in school contexts. As such, this chapter begins with an explanation of situated learning theory to show how social processes serve as a framework for understanding the mechanism of teacher learning and change through mental health training and PD. Similarly, the teacher mental health framework is described to explain how PD leads from having mental health awareness to become expert teachers. The chapter also presents a broad review of the elements of effective PD formats and content necessary to improve teacher knowledge and self-efficacy of student mental health needs.

Theoretical Framework

This section of the chapter presents a synthesis of current research on PD research in the area of teacher mental health awareness. Three major considerations guided the literature synthesis. The first draws on situated learning theory, which suggests that learning occurs within social interactions within a specific context (Mitchell et al., 2008). Additionally, the chapter considers the teacher mental health framework developed by Weston and colleagues (2008). The framework provides six principles for teacher learning about student mental health. Finally, the synthesis examines the core elements of effective PD guidelines.

Situated Learning Theoretical Framework

Although there are multiple explanations of a situation learning approach, the common tenet among them is that the specific environment of the learner is essential to the learning process (Gee, 2008; Lave & Wenger, 1991). Situated learning theory underscores the importance of context in the construction of knowledge as well as a practical application within the specific environment (Brown et al., 1989). As such, teachers seeking to improve their practice to address everyday issues in their classroom learn from others through personal connections and shared expertise (Mitchell et al., 2008).

Lave and Wegner's (1991) seminal study on situated learning emphasized the importance of authentic practice and social interaction. The study results illuminated that learning rarely occurs in isolation or out of context. Specifically, the authors suggested that as learners engage in the context and learning community, they gain expertise and extend meaning as they develop new content knowledge. The researchers noted that as learners interact with a community in context, they slowly learn to perform small tasks (peripheral participation) until they can complete complex tasks (full engagement).

When applied to staff development and teacher learning, situated learning theory recognizes that teacher learning results from enculturation of practice within a professional community with colleagues and knowledge construction (Borko, 2004; Lave & Wenger, 1991). As such, effective instructional skills cannot simply be transferred to teachers to improve their recognition and response to students experiencing mental health needs. However, Brown, Duguid, and Collins (1989) suggest that instructional approaches including cognitive apprenticeship promote teacher learning through mentorship, authentic activities, and social interactions. This cognitive apprenticeship model fits within the situated learning theory by promoting learning through active engagement in professional learning with others in the situated context (Brown et al., 1989).

Thus, social interaction and collaboration are essential components for PD experiences. Little (2002) posits that strong PD and collaborative communities contribute to instructional improvement. Crosby et al., (2015) postulate that teachers must practice symptom recognition and behavior management strategies within the school setting to become experts in working with students with mental health disorders. Therefore, authentic experiences in recognizing and managing student behaviors, mentorship with experienced individuals and social interactions within the context can help teachers progress in their readiness to work with students with mental health needs (Brown et al., 1989; Crosby et al., 2015; Lave & Wegner, 1991).

Teacher Mental Health Framework

Students exhibiting symptoms of mental health problems often received limited school-based services, as teachers report insufficient PD in supporting children with mental health needs (Kataoka et al., 2002). Teacher preparation programs have not afforded teachers with the understanding of student mental health disorders to meet the complex demands in elementary

classrooms (Weston et al., 2008). However, teachers report the need and desire to receive the knowledge and skills necessary to feel efficacious when responding to students with mental health needs (Koller et al., 2004). To ensure that teachers increase their knowledge and skills to improve their interactions with children with mental health disorders and those returning to school after psychiatric hospitalization, Weston et al., (2008) developed the teacher mental health framework for helping teachers competently support student needs. The framework and principles provide structure for the basic knowledge and skills needed for teachers. The framework includes six principles, including key policies, learning supports, data collection, communication and relationships, engagement in multiple systems, and personal well-being.

Furthermore, the framework seeks to help make appropriate distinctions among teachers of varying levels of experience working with students with mental health issues. Teachers with more experience and expertise can serve as mentors and teacher leaders. As such, training and PD for beginning teachers should build a solid foundation of awareness and basic skills in mental health needs, while advanced practitioners will have the opportunity "to apply knowledge with greater depth, flexibility, and adaptability" (Weston et al., 2008, pg. 28). Likewise, master teachers will develop the skills to fully integrate their knowledge and skills to meet student needs.

Elements of Effective Teacher Professional Development

Given the complexity of student mental health needs and the reintegration process, teachers have reported the need for PD in disorder recognition and behavior management (Clemens et al., 2010; Savina et al., 2014). The most prevalent form of PD appears to be lecture-based workshops (Reinke et al., 2014; Sutherland et al., 2013; Brock & Beaman-Diglia, 2018). Current literature suggests that single time lecture-based workshops are insufficient in preparing

teachers to respond to students exhibiting mental health needs or to meet student needs for returning to school environments (Brock & Beaman-Diglia, 2018; Brock & Carter, 2015).

Teacher learning can occur in many different aspects of practice. For instance, teacher learning takes place in "their classrooms, their school communities, and PD courses or workshops. It can occur in a brief hallway conversation with a colleague, or after school when counseling a troubled child" (Borko, 2004, p. 4). However, student confidentiality must be taken into account when discussing any student diagnoses and classroom problems (Blizzard et al., 2016).

The need to develop mental health literacy, knowledge about disorders, recognition of symptoms, ability to seek referrals for students in crisis, and student behavioral management skills among teachers has been highlighted by teachers' reports of feeling inadequately prepared to meet student needs. However, it is not sufficient to provide "one-off" workshops with facts about mental health illness and expect teacher practices to change (Whitley et al., 2012). Rather, literature proposes that effective PD programs must include social learning, active learning, and extended duration (Garet et al., 200; Jensen et al., 2016; Learning Forward, 2011)

To understand the importance of content during PD, Garet and colleagues (2001) designed a study to examine how PD elements change teachers' knowledge, skills, and classroom practices. Specifically, the authors integrated, and operationalized core elements of PD as cited in the literature. As such, the authors studied structural aspects of PD, particularly the format, duration, and degree of contact collaboration of the activities. Furthermore, the authors studied the core features of the PD, including content focus, active learning, and coherence. The researchers used data from the Teacher Activity Survey conducted as part of a national survey; this included responses from 1,027 teachers from 358 districts nationwide. Key

results from the study indicate that sustained and intensive PD is more likely to impact teachers' knowledge and skills than those with shorter duration. Additionally, PD that focuses on content and allows for hands-on or active learning enhance teacher learning.

Active Learning

The traditional one-time conference approach to PD provides a fragmented, episodic approach to teacher PD that does not offer rigorous learning (Knapp, 2003). Effective PD deepens teachers' knowledge, transforms teaching (Borko, 2004) and is characterized by teachers' engagement in active learning (Darling-Hammond & McLaughlin, 1995). Desimone (2009) notes that active learning includes sustained learning opportunities that can occur in a variety of forms, including coaching, modeling, working with expert teachers, and self-reflection.

With that in mind, Tschannen-Moran and McMaster (2009) suggest that teachers often do not show self-efficacy in implementing new strategies after receiving information from one-time PD sessions. Their study of increasing self-efficacy when implementing a new classroom strategy implies that PD opportunities that include information presentation, followed by modeling, practice, and coaching in the teachers' context improved teachers' self-efficacy in the implementation of a new strategy. Bandura (1997) also suggested that authentic task-specific experiences increase self-efficacy in implementing new strategies in classroom contexts.

Active learning may also include being "carefully supervised from master teachers," because expert teachers have access to the latest strategies from research and practice (Mehta et al., 2015). King et al., (2014) explored how teachers and therapists believe they develop the knowledge, skills, and adaptability to meet student mental health needs, mainly when responding to situations that involve unpredictability. Nine mental health specialists and five teachers

participated in the study. The authors utilized a cross-group analysis procedure to compare and contrast the differences between therapists and teachers. Key findings revealed that teachers believed that learning from expert teachers allowed for growth in working with students with mental health issues. Teachers also reported being open to feedback improves the quality of teaching and interactions with students. Furthermore, teachers suggested that this helps them progress in their ability to apply disorder knowledge into real-world situations.

Content Focused

Literature on teacher education and training indicates that content-focused PD results in transference of learning into practice (Desimone et al., 2009; Learning Forward, 2011). PD focused on specific content increases teacher knowledge and skills in that area (Desimone et al., 2009). PD should intentionally provide content to enhance teachers' competence in pedagogical skills to teach or respond to student needs based on results from a study (Darling-Hammond & Richardson, 2009). Teachers report increased self-efficacy when PD is coherent and focused on needed content knowledge that aligns with school goals and policies (Darling-Hammond & Richardson, 2009).

Extended Duration

Supporting situated learning, Chaaban (2017) highlighted the importance for teachers to have sufficient time to consolidate their new learning acquired from the PD. While there is no consensus on the optimal duration of PD, the amount of time engaged in active learning also influences teacher learning and increases in self-efficacy (Darling-Hammond & Richardson, 2009). Borko (2004) notes that effective teacher PD options include intensive workshops. According to Guskey's (2002) model of teacher change, cognitive knowledge and PD alone is not sufficient for changes in practice. Rather, Guskey (2002) suggests that teachers commit to

new practices only after engaging in modeling and practice until they see repeated success. With that in mind, there is compelling evidence to support extended PD models in promoting new learning and practice changes (Desimone, 2009; Desimone et al., 2006; Garet et al., 2001; Yoon et al., 2007). In a meta-analysis of nine studies on PD that examined and compared workshop and institute PD methods, Yoon and colleagues (2007) found that PD opportunities lasting more than 14 hours showed changes in teacher instructional practices, as well as improvements in student achievement. Conversely, studies which examined PD sessions of less than 14 hours did not results in improved student outcomes. While there is not a consensus of a required duration of PD experiences, these results align with Darling-Hammond and Richardson (2009) recommendations that that teachers participating in 30-100 hours of content-specific PD over six to 12 months show the largest intervention effects. Desimone (2009) also recommends that PD models that stretch across a semester include at least 20 hours of contact time.

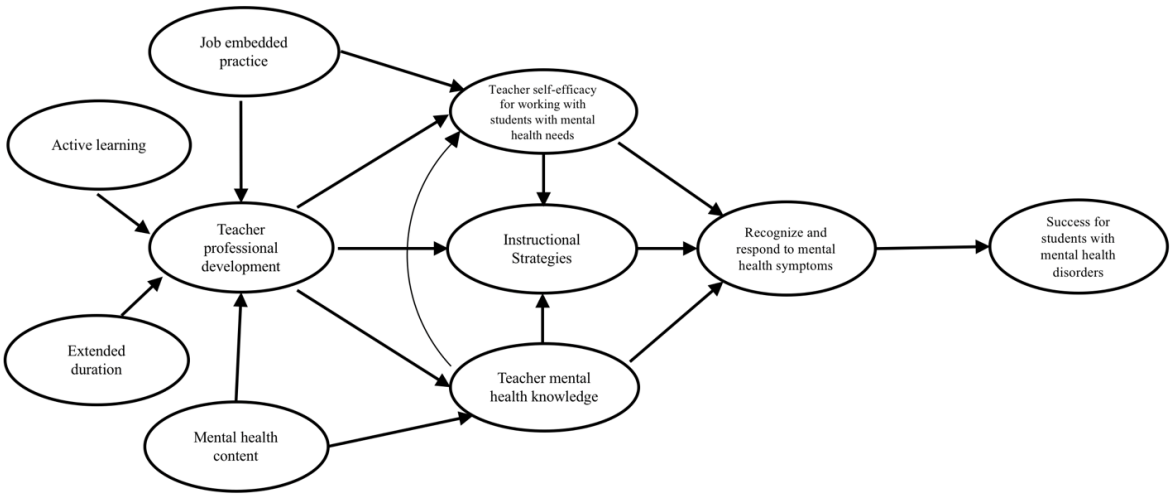
Additionally, Borko (2004) recommended that teachers who engage in intensive PD workshops also receive ongoing support throughout the school year to deepen their understanding of the content learned. Teachers who received brief coaching for working with students returning to the classroom following psychiatric hospitalization indicated that they needed continued support in classroom management strategies (Crosby et al., 2015). Rock et al. (2013) confirmed that elementary teachers working with students reported a continued desire to access skilled teachers or practitioners upon whom they can rely to ask advice, particularly in the area of classroom management when working with students with childhood psychiatric disorders.

Conceptual Framework

The situated learning theory (Lave & Wenger, 1991), teacher mental health framework (Weston et al., 2008), and elements of effective PD (Desimone, 2009; Jensen et al., 2016; Learning Forward, 2011) frame the following review of research literature on potential interventions to increase teacher knowledge of mental health disorders and self-efficacy in responding to students' mental health needs. The guiding frameworks postulate that teachers learn best through active and collaborative opportunities that focus on content specific to mental health (Borko, 2004; Weston et al., 2008). Taken together, for this research review and intervention, a conceptual framework (see figure 2) incorporated by these three frameworks connects PD to the intended outcomes of the intervention. The intervention aims to increase elementary teachers' knowledge of mental health disorders, as well as increase teachers' self-efficacy in recognizing and responding to students' mental health needs. Teacher PD that incorporates active learning through sustained duration and develops teachers' mental health recognition and classroom strategies to recognize and respond to mental health symptoms will reinforce the outcomes of this study.

Figure 2

Conceptual framework connecting professional development to the goal of student success



Mental Health Content Knowledge and Skills for Teachers Literature

Teachers must have more than a basic awareness that childhood mental health issues exist to assist students with mental health disorders as they experience social, emotional, and behavior challenges (Fortier et al., 2017). With that in mind, teachers need knowledge of mental health disorders, as well as helping behaviors to respond to student needs (Fortier al., 2017). It is essential that teachers are equipped with sufficient mental health literacy to utilize the skills and strategies taught through various PD formats (Whitley et al., 2012). Mental health professionals suggest that mental health literacy includes having adequate knowledge of mental health disorders to support the recognition and management of symptoms (Kutcher et al., 2016). Likewise, mental health literacy for teachers incorporates the ability to utilize effective strategies for students exhibiting psychiatric symptoms, as well as administer first aid for those in distress (Jorm, 2012). Kutcher (2012) notes that mental health literacy PD affords educators the opportunity to recognize signs and symptoms of childhood disorders, provide support for students exhibiting mental health needs, and know when to make necessary referrals to school support staff, including social workers and psychologists. Furthermore, Kutcher et al., (2013), who all work in the area of psychiatry, suggest that teachers with high mental health literacy may be better equipped to distinguish between mental health disorders and mental distress in students. This section examines current literature associated with what information and strategies teachers need to be effective in working with students with mental health disorders, including those reintegrating into the school environment after hospitalization.

Symptom Content for Teachers

Teacher PD in childhood mental health disorders influences classroom environments. Although teachers are often trained in recognizing typical and atypical development such as

learning disabilities, the lack of mental health PD often leads to misconceptions and stigma surrounding childhood psychiatric disorders (Winters, 1997). Current literature shows that increased teacher knowledge about psychiatric disorders and symptoms may lead to improved attitudes and less-stigmatizing behaviors toward students with mental health needs (Balkin & Roland, 2007; Clemens et al., 2010; Crosby et al., 2015). Teachers' perceptions of students with mental health issues and disorder misconceptions are barriers to access to mental health services; the educational system plays a key role in the referral process for services (Pereira et al., 2015).

This view is consistent across a study conducted by Crosby and colleagues (2015). The researchers examined teachers' knowledge, self-efficacy, and beliefs and behaviors toward students with mental health disorders after using the Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (Wolpow et al., 2016). The qualitative study relied on five focus groups to understand teachers' perspectives, challenges and needs for working with students with mental health disorders, particularly those exhibiting externalized behaviors. During the focus group interviews, 22 students were identified as presenting behaviors that were difficult to manage. Participants expressed during the interviews that understanding mental health symptoms changed their perceptions of the students' behaviors. Specifically, one participant noted that understanding the symptoms reframed her understanding that the intervention provided insight that reasons for symptoms and behaviors exist, rather than children coming in and choosing to be manipulative or aggressive.

Crosby and colleagues' (2015) assertion that mental health knowledge increases teachers' awareness of mental health symptoms is consistent with Ko et al., (2008) findings which suggest that increased knowledge of symptoms helps teachers appreciate students' classroom needs. Children may face academic and emotional challenges when returning to school after inpatient

psychiatric hospitalization (Weiss et al., 2015). Specifically, students report anxiety and increased disorder symptoms when returning to school, while teachers note concerns about disruptive behaviors in the classroom (Simon & Savina, 2007). Some teachers believe that students should return to the hospital if disorder symptomology and adverse behaviors were still present at the time of return (Weiss et al., 2015). With that in mind, teachers require training in disorder symptomology to understand that children returning from hospitalization may have on-going needs (Clemens et al., 2010).

Specifically, schools provide a point of access for mental health interventions and school services for children (Kutash et al., 2006). As such, schools and teachers are integral for increasing access to school mental health services (Ball et al., 2016). Thus, teachers play a critical role in making appropriate referrals for students exhibiting mental health needs (Ball et al., 2016). Jorm and colleagues (2010) suggested that to make student referrals, it is essential for teachers to recognize early signs of mental health issues. To improve teachers' recognition of early signs of emotional and behavioral changes in students, as well as signs of distress, the authors utilized a cluster randomized trial to study the impact of implementing a modified version of the Mental Health First Aid intervention program with educators to improve mental health knowledge. Teachers at seven Australian schools received an intervention presenting information about common problems, including depressive and anxiety disorders, suicidal thoughts, and self-harm. Additionally, teachers received information and training on how to apply a mental health action plan for students exhibiting disorder symptoms. Teachers at another seven Australian schools were waitlisted for future training. The intervention included the use of such strategies as using vignettes of students with depressive symptoms to help teachers recognize symptoms and engage in discourse about how to respond to students. Key results

showed that trained teachers had high recognition of depressive symptoms and recognition of effective ways of responding to students. Gaining recognition of symptoms and strategies to assist students increased teachers' knowledge and confidence in working with students with mental health disorders. However, the researchers found that the modified Mental Health First Aid program did not have a significant effect on teachers' helping behaviors, including referral making. They note that a limitation of the study was timing; to accommodate teachers' schedules, the intervention was shortened in duration from 14 to seven hours. As Garet et al., (2001) suggest, with limited contact hours PD may not result in teacher change.

Likewise, Powers and colleagues (2014) conducted a study to increase teachers' knowledge of mental health disorders. The study included 157 elementary teachers from eight schools. The PD workshop included information about prevalence and symptomology of common childhood mental health disorders. The lecture-style PD also included misconceptions about mental illness, consequences of untreated mental health symptoms, and barriers to families accessing or continuing mental health care. Social workers presented all of the PD information. Teachers completed pre-and-posttests; the researchers used a paired t-test to analyze changes in knowledge of the content areas taught. The results showed statistically significant changes in teacher knowledge about disorders. Furthermore, the results indicated that there was a statistically significant change in teachers' ability to recognize symptoms of common childhood disorders, as well as signs of distress.

Recognition of signs and symptoms may lead to teachers making appropriate interventions and service references for students exhibiting externalized and internalized behaviors (Reinke et al., 2011). This reflects principle one of the teacher mental health framework by Weston et al., (2008). According to Weston et al., (2008), principle one includes

the ability to recognize and address non-academic barriers to learning. Moreover, recognition of symptoms and signs of distress focuses on principle two, noting that the teacher demonstrates content area knowledge, as well as linking that knowledge to gain an understanding of identification, referral, and intervention for students who require school support.

Principle three of the teacher mental health framework shows that with a greater understanding of symptomology, teachers should learn to determine the link between symptoms and behavioral deficits (Weston et al., 2008). Likewise, Crosby et al., (2015) study indicated that teachers should learn to build skills, including deescalating externalized behaviors rather than punishing behaviors A study by Fortier and colleagues (2017), based on the School Mental Health ASSIST (SMH-ASSIST) framework posits that sequence and differentiation in professional learning experiences influence teacher mental health literacy and, ultimately, helping behaviors. SMH-ASSIST explicitly attends to enhancing teachers' mental health knowledge, understanding, skill, and confidence. Teachers must receive a deeper level of mental health literacy before being able to implement strategies to support students with mental health problems and intervene when they exhibit problems, such as externalized behaviors or distress. Based on the SMH-ASSIST model, Fortier et al., (2017) designed a case study to examine increases in teacher knowledge, and the ability to notice mental health symptoms in students over a five-year period. The researchers studied intentional scaffolding in professional educator learning, rather than examining one specific program. In fact, the authors implemented programs such as Bounce Back, Resilient Classrooms: Creating Healthy Environments for Learning, and The Mental Health Curriculum Guide: Understanding Mental Health and Mental Illness**.** The programs offered topics related to specific mental health diagnoses, including symptoms and risk factors. The researchers collected pre and post data from approximately 3,900 teachers in 2010

and again in 2015 using the Mental Health Literacy and Capacity Survey for Educators. T-tests were performed to test for statistical significance of the mean scores across survey years for the different items, including symptom recognition. Results showed that increases in teachers' knowledge of mental health disorders were statistically significant. Survey results revealed that teachers gained awareness for the range of mental health issues that children experience during school years, risk factors and causes of mental health issues, signs and symptoms of specific disorders. Teachers also gained a novice understanding of provisions of social and emotional classroom supports for students.

Understanding roles within the school system is an important consideration when providing educator mental health literacy PD opportunities. The intensity of information presented about mental health disorders should reflect staff role expectations (Short, 2015). Teachers require more than basic mental health awareness of types and prevalence of childhood disorders because, in their role, they have daily interactions with students and need to identify students experiencing challenges and distress (Fortier et al., 2017; Reinke et al., 2011). Teachers working with children returning to school after psychiatric hospitalization require knowledge of symptoms and behaviors related to the specific mental health issue that precipitated the hospitalization to notice and seek assistance for changes in student behavior or emotions, as well as to make appropriate classroom accommodations (Weiss et al., 2015). While this is true, increasing knowledge of student mental health while ensuring that teachers' professional boundaries and adherence to practice are maintained is essential (Reinke et al., 2011). Professional learning interventions should establish clear expectations that teachers remain focused on observable student behaviors to assist them in the classroom, not make diagnoses that are outside of their scope of practice (Fortier et al., 2017).

Classroom Strategies

Teachers with awareness and knowledge of mental health issues are well-positioned to act in supporting students in the classroom environment (Moor et al., 2007). Just as mental health literacy PD aims to increase teachers' knowledge of disorders, it also must include strategies for managing and preventing mental health problems in the classroom setting (Jorm, 2012; Imran et al., 2018). A mixed-methods study conducted by Hussein and Vostanis (2013) showed that mental health knowledge was not enough to help teachers successfully work with students with mental health problems. Instead, the teachers requested additional time to practice activities related to classroom management and behavioral techniques.

With that in mind, Frauenholtz et al., (2017) recently conducted a qualitative study to examine the role of teachers' mental health knowledge in supporting student academic and behavioral needs. Specifically, the authors aimed to examine how mental health literacy influences interdisciplinary collaboration. Study participants, drawn from a convenience sample, included school staff, mainly teachers, and mental health providers, such as social workers and case managers. During the study, the participants engaged in focus groups which asked about previous experience with students in mental health distress, mental health literacy training, and their knowledge in being able to identify students in distress and work with others to respond to these needs. The authors coded the transcripts for themes. Key results revealed that teachers noted that they are confident in instructional practices, but they lack the skills to intervene when a child experiences mental health problems and distress. Participants reported that their limited familiarity with classroom skills and strategies to support students sometimes led to the teacher attempting to intervene only when the child's behavior or symptoms reached a crisis point. Likewise, mental health professionals expressed frustration that teachers lacked skills in knowing

how and when to refer students for necessary additional mental health services. One mental health provider participant recognized that teachers carry multiple responsibilities, primarily educational activities, and should not be expected to know how to handle all student mental health issues; however, teachers should have basic skills to intervene when a child presents signs of changing symptoms.

Teacher mental health literacy includes the ability to recognize risk factors and symptoms of mental health conditions (Fortier et al., 2017). Kutcher et al., (2013) aimed to gain a greater understanding of teacher mental health literacy by examining classroom strategies. Specifically, the authors wanted to understand the skills and strategies utilized by teachers, suggesting that being able to respond to student mental health needs is necessary in order for schools to provide effective mental health promotion and prevention programming. To support teachers' implementation of the Mental Health Curriculum Guide with students, the authors presented an eight-hour training focused on enhancing teacher mental health literacy and strategies to use with students experiencing mental health problems. During the training, the trainers desired to facilitate discussion related to teaching strategies to scaffold the development of knowledge related to mental health and practical classroom strategies. Eighty-Nine Canadian teachers participated in the training session. The results showed that teachers reported finding the training practical and relevant to their daily interactions with students. Also, teachers stated that having behavior management strategies made them more confident in addressing mental health needs in their classrooms. Teachers also felt better prepared to implement the Mental Health Curriculum Guide with students as a result of their increased mental health literacy.

In a Canadian national teacher survey, Froese-Germain and Riel (2012) discovered that 68.4% of elementary teachers had not received training in how to support students experiencing

mental health needs, such as acute distress. With that in mind, 96% of teachers reported feeling ineffective in helping students, thus, needing skills and strategies to support students, especially those with externalized behaviors. Elementary teachers noted that knowledge in recognizing mental health disorder symptoms is insufficient in helping students, they need classroom and behavior management strategies to help support students. As such, teacher training should include strategies to help address immediate mental health related challenges, promote positive mental health, and the capacity to seek referrals from the appropriate providers, including the school social worker or psychologist, if necessary (Kutcher et al., 2013). Weiss et al., (2015) suggest that student-specific academic and behavioral classroom interventions are necessary components of teacher psychoeducation when students return to school after hospitalization.

Weston et al., (2008) posit in principle four that developing interpersonal relationships is an essential skill. Wolpow et al., (2016) suggest that PD should include specific strategies to mitigate stimuli triggers in the classroom setting, as well as using peer-coaching to assist students after returning to school following hospitalization. Such programs as The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (HLT; Wolpow et al., 2016) incorporate elements of Universal Design for Learning (UDL) to design instruction and utilize strategies that are accessible to all students and teachers. UDL theory that allows teachers to meet standards and classroom expectations, while addressing student needs (Rose et al., 2002). With that in mind, UDL helps remove barriers from teaching methods and curriculum methods to provide multiple ways to engage learners (Rose et al., 2002). Such PD interventions as the Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success intervention program offer strategies for working with students with mental health disorders, particularly those with externalized behaviors; however, guided by UDL theory, various

strategies also encourage social-emotional and behavior management strategies that are appropriate to use with all students in classroom settings (Wolpow et al., 2016).

Cultural Awareness

Knowledge of specific cultural practices and views of mental health can increase teacher compassion, sensitivity, and respect for the children they serve, increasing the effectiveness of working with children returning to school after psychiatric hospitalization (Wolpow et al., 2016). For instance, Weiss et al., (2015) suggest that teachers should be aware of family experiences and concerns during the hospitalization period and the transition back to school. The researchers, consisting of psychiatrists and social workers, suggest that teachers should discuss family factors including stress, questions and concerns about mental health diagnoses, and desire for school assistance during the transition process. Furthermore, teacher mental health PD necessitates differentiated training to build understanding and supports for students from specific cultures (Fortier et al., 2017).

Individuals respond differently to mental health issues and support depending on cultural norms and perspectives (Wolpow et al., 2016). A study by Trainor (2010) of parental interactions with special education services showed that parents across various socioeconomic and ethnic backgrounds responded differently to their child's diagnosis and need for school services. Specifically, the ethnographic study consisted of focus groups and interviews with 27 parents. White, African American, Native American, and Latino parents participated in the study. Results showed that White and educated parents were typically more accepting of their child's diagnosis. Contrastingly, the author noted that Latino and Native American parents showed a greater distrust of diagnoses. As such, Crosby (2015) recommends that schools develop and reinforce cultural competence and sensitivity when working with students and families of students with

mental health issues. Ming and Dukes (2006) encourage teachers to reflect on the cultural beliefs of students when planning mental health supports.

Effective Professional Development Formats

PD in education can be defined as any activity that is intended to prepare school staff to improve their performance in their current or future roles in the school setting (Little, 1987). As such, PD conceptualization includes learning that occurs in the classroom environment, school communities, courses and workshops, and collaboration with colleagues (Borko, 2004). The intention of each of these activities is to promote the effectiveness of instructional practices (Desimone, 2009).

In the context of a suburban elementary school, providing PD opportunities on mental health symptoms and strategies is a chance to become more knowledgeable and efficacious in helping students return to school following psychiatric hospitalization (Reinke et al., 2011). Modeling, collaboration, and feedback increased teachers' strategy use and helping behaviors, such as making referrals to other school staff and outside resources (Powers et al., 2014). PD should increase changes in teacher practices (Guskey, 1986). This section presents information and research on the effectiveness of current PD practices that help increase teacher knowledge and efficacy in utilizing strategies to respond to student mental health needs.

Communities of Practice

Communities of practice (CoP), informed by situated learning theory, form as the result of a shared learner desire to learn within a framework of voluntary social interactions and collaboration (Wenger, 2007). With that in mind, Wenger (2007) suggested that three elements defined CoPs and separated them from other forms of learning communities, including domain, learning, and practice. These three elements allow for learners to engage and acquire knowledge

in the CoP. Specifically, members in the CoP must share a common vision and pursuit of knowledge in a domain of interest (Wenger, 1998). CoP members engage in common discussions and collaborative activities to support their learning and build relationships with other community members. As such, learning occurs with CoPs through learning with others in specific contexts, including school settings (Lave & Wenger, 1991). Research on effective PD highlights the importance of collaborative learning environments to promote the improvement of teachers' practice and interactions with each other and students (Darling-Hammond & McLaughlin, 2001; Darling-Hammond & Richardson, 2009).

Interdisciplinary Collaboration

Current literature suggests that effective student mental health CoPs promote interdisciplinary participation (Clemens et al., 2011). According to principle five in the mental health framework (Weston et al., (2008) principle five promotes teachers' engagement and practice across multiple contexts. With that in mind, principle five recommends that collaboration is necessary in working with colleagues to identify needs and resources that help support students with mental health needs. School interdisciplinary collaboration includes working with mental health professionals.

Mental health professionals suggest that, similar to the reintegration process for students with physical illness, students returning to school after psychiatric hospitalization benefit from including various stakeholders' input in the return plan (Clemens et al., 2011). This recommendation comes from a study by Clemens et al., 2011, which examined factors that facilitate successful school reentry. Specifically, the researchers interviewed mental health professionals from public and private institutions, as well as school mental health professionals. Qualitative analysis of the interviews indicated that including mental health providers, teachers,

administrators, and school social workers communicating and collaborating to learn about students' needs reduces barriers related to the coordination of school based support, familial expectations, and academic goals. Including mental health professionals in CoPs provides an opportunity to collaborate about crisis interventions, educational programs for children, and develop shared goals and language (Waxman et al., 1999). Currently, the IDEA Partnership, funded by the Office of Special Education Programs, sponsors the National Community of Practice to allow interdisciplinary collaboration about special mental health topics, including teacher understanding of student mental health, integrating education with systems of care, and family-school partnerships.

According to Phillippo and Kelly (2014), mental health professionals and educators often do not interact, although teachers often encounter student mental health issues. Additionally, teachers often provide psychosocial support for students in classroom settings. In light of this, the researchers wanted to gain a deeper understanding of the effects of collaboration between teachers and school-based mental health professionals (SBMHP). Teachers and SBMHP from three high-schools, each enrolling primarily students of color from low-income families, participated in the study. The authors engaged in observation and interviews during the ethnographic study over six weeks. The authors found that collaborative sessions allow teachers to debrief about student behavioral incidents and determine effective strategies from mental health professionals and other teachers to use in the future. Furthermore, the results showed that teachers who collaborated with other teachers and SBMHP attempted to address student needs in the classroom. Additionally, study participants reported working together to brainstorm responses to student challenges and accommodations, with each participant adding relevant perspectives and knowledge of the students. Participants also contributed relevant skills to the

group. As such, teachers' self-efficacy increased in being able to respond to students when mental health issues arose, particularly student crisis situations.

Similarly, Handley and McAllister (2017) conducted a two-part study to understand the effects of stakeholder collaboration in understanding student mental health. The authors wanted to gain a richer understanding of the facilitation of knowledge transfer, creativity, and access to broader networks as educators and mental health professionals developed an understanding of student experiences with mental health issues through a collaborative approach. In 2011 and 2014, the authors interviewed 8 teachers on the process, including observed changes in student changes. The interviews showed that the collaborative process met school priorities; teachers gained knowledge in mental health symptoms. In the second phase of the study, the researchers interviewed 214 elementary teachers from 20 schools. The interviews showed that the collaborative approach provided opportunities for conversations, as well as becoming solution driven. Collaboration between teachers and mental health professionals also minimized the burden on schools to provide trained facilitators to initiate conversations about perceived and observed mental health needs, as well as provide mental health information.

Although the study showed CoPs including mental health professionals to be effective in increasing teacher knowledge and self-efficacy, organizational issues contributed to scheduling obstacles (Phillippo & Kelly, 2014). With that in mind, Weist et al., (2012) posits that CoP meetings should be regular, structured, and focused; scheduling conflicts create complications for interdisciplinary collaboration to exist in this manner. Collaboration between educators and mental health professionals often proved to be difficult because of tight schedules, resulting in difficulty fitting meetings and collaboration into workdays (Handley & McAllister, 2017).

Caregiver and Teacher Collaboration

Along with collaboration between educators and mental health professionals, current literature also suggests that parental input is necessary in helping teachers understand mental health problems in specific students as they reintegrate into school settings (Blizzard et al., 2016; Weiss et al., 2015). Blizzard and colleagues (2016) note that involving parents in collaborative meetings with teachers, as well as mental health providers, increases the development of appropriate transition plans for students and psychoeducation on mental health disorders. Specifically, the researchers conducted a study examining the effectiveness of the School Transition Program (STP). The purpose of STP is to promote successful school reintegration for students by bridging the gap between the hospital, home, and school settings by providing opportunities for communication and collaborative problem-solving among stakeholders. As such, 63 parents of students returning to school following psychiatric hospitalization participated in the mixed methods study to provide data about their experiences collaborating with mental health professionals and school staff. Quantitative survey and focus group interview data indicated that parents felt empowered by being part of the transition process. The collaborative process provided parents with information about their child's disorder, although they felt it was not enough to assist with daily home struggles, including behavioral issues. With that in mind, parents felt that school staff did not understand their child's disorder or needs and would like to have increased time with teachers to better provide accommodations for student social and academic needs.

Collaboration between teachers and caregivers affords teachers insights into caregivers' perceptions of the academic and emotional challenges that their child faces when returning to school. (Weiss et al., 2015). Meetings and cooperation between families and school staff likely

increases the chance that parents and teachers will establish common goals for students, as well as discuss and adapt individualized transition plans based on the students' mental health needs, strengths, and desired academic, emotional and social goal (Blizzard et al., 2016; Weiss et al., 2015).

A study designed by Kutash et al., (2013) also examined the impact of caregiver and school collaboration on academic and social outcomes for students with histories of mental health disorders. During the study, the researchers provided family education of mental health disorders, school procedures and processes, and services provided through school-based mental health providers. Likewise, the study provided opportunities for parents to engage and collaborate with school staff about student needs in the school setting. The randomized control study was conducted over the course of one school year. The purpose of the intervention was to increase parent engagement and communication with teachers, as well as parental engagement in school activities. The authors suggested that previous research found that school engagement and communication with school staff led to increased chances that appropriate accommodations and evidence-based practices were used with students with mental health needs.

The participants in both the intervention and comparison groups received information related to special education and other school services, as well as parenting skills and resources. The intervention group also had the chance to participate in collaborate sessions with teachers and other parents. Process measures were utilized to capture several components of implementation fidelity, including dose, adherence, participant responsiveness, and program differentiation. One hundred twelve caregivers participated in the study; a total of 56 caregivers participated in the intervention group and 56 caregivers participated in the comparison group. Participants completed the Caregiver Strain Questionnaire (CGSQ; Brannan et al.,1997) and the

Parent- Focused Role Construction Scale (Hoover-Dempsey & Sandler, 2005). Furthermore, the researchers also conducted semi-structured focus group interviews with caregivers in the intervention and comparison groups. Key results showed that parents in the intervention group experienced increased involvement and engagement in their child's education than parents in the comparison group. Likewise, parents in the intervention group who were more involved in discussions with school-based mental health providers, including social workers, and teachers reported more engagement in making school-related decisions. The authors posit that more research should be conducted to understand the frequency and content of parent-teacher communication and collaboration to examine student academic and social success in school settings.

Educator Collaboration

School practices and policies indirectly affect students returning to school after psychiatric hospitalization through the school climate (Crosby, 2015; Ringeisen et al., 2003). Creating a school-wide welcoming and sensitive culture toward students with mental health needs requires that school administrators assess current policies and staff training needs (Cole et al., 2005). Crosby (2015) proposed that regular staff collaboration through CoPs addresses teacher beliefs about student mental health and offers the opportunity for staff to develop student strategies collaboratively. By fostering collaboration, CoPs guide teachers away from making isolated decisions (Kruse et al., 2015). Instead, teacher collaboration is a powerful learning experience that allows teachers to engage in "collective work on authentic problems that emerge out of their problems (Darling-Hammond & McLaughlin, 2001).

In CoPs, groups of people who share similar interests, concerns, and problems deepen their knowledge and effectiveness by interacting regularly. Educators collaborating to improve

their ability and self-efficacy when working with students with mental health needs should cooperate to improve strategies for identifying students who need service, implementing strategies for supporting students, utilizing universal prevention programming with students (Weist et al., 2012). Thus, CoPs seek to provide the supportive communications and reflections to enable people to discuss and learn from collective intelligence, sharing, and support to advance mental health literacy among teachers (Wenger et al., 2002). According to Fullan (2002), mental health knowledge develops through social processes such as collaboration.

While collaboration with mental health professionals proved to be difficult, researchers illuminate that CoPs consisting of teachers and other school staff are also effective because teacher collaboration is meaningful and applicable to classroom teaching and specific contexts (Capobianco & Joyal, 2008; Mitchell et al., 2009). McHargue (1994) notes that during collaborative PD, teachers learn best from other teachers, as it creates collective knowledge, problem-solving, and creativity to solve problems in their practice. Teachers collaborating with other teachers creates shared expertise (McHargue, 1994). Expert and mentor teachers knowledgeable in topics, such as student mental health, can serve as teacher leaders in CoPs and promote awareness, knowledge, and practical classroom strategies (Cochran-Smith, 1991). Expert teachers commit to continuous learning, topic knowledge, educational context, and the change process, encouraging the cultivation of professional growth and student achievement (Wilson, 2016).

The research study conducted by Garet et al., (2001) mentions the benefits of teacher collaboration. In fact, the study showed that CoPs among teachers had potential benefits, including increased comfort level, which may lead to engagement. The authors suggested that teachers who work together are more likely to feel comfortable discussing problems, content,

and skills that arise in the classroom and during the PD experiences. Furthermore, the researchers postulate that teachers from the same school are likely to share resources, as well as discuss student needs of shared students.

Didactic Workshops

Didactic workshops and conferences, which are the most common PD format, allows schools the opportunity to provide information to large groups of teachers and other school personnel (Powers et al., 2014). Such PD formats encourage learners to develop a common understanding among all participants (Powers et al., 2014). Furthermore, situated learning is explained as the construction of knowledge through sociocultural activities (Lave & Wegner, 1991); however, learning is also an active individual construction process (Cobb, 1994). Therefore, individual acquisition of knowledge and efficacy, as well as how this influences behavior is essential (Borko, 2004).

Workshop Models

Successful student reintegration after psychiatric hospitalization necessitates teacher knowledge and understanding of disorder characteristics (Crosby et al., 2015; Sexson & Madan-Swain, 1993). Interventions improving teachers' skills and knowledge impact student success (Rowling, 2009). Literature related to school reentry for children with chronic health issues illuminates that teachers offered training opportunities that help develop high levels of understanding about illnesses increased their self-efficacy and changed behaviors, including learning to make appropriate learning and behavioral adjustments, including flexibility with deadlines (Sexson & Madan-Swain, 1993).

Moor and colleagues investigated teacher workshop effectiveness by examining teacher recognition of symptoms, as well as change in attitudes about students with mental health needs.

One hundred fifty-one teachers from eight schools in Scotland participated in the study and were assigned to the experimental or control group. The authors offered a two-hour training session that featured a presentation on the risk factors of depression and a video featuring the signs and symptoms of childhood depression. The video showed how symptoms could present in the classroom setting. The authors also utilized vignettes depicting a range of student difficulties that teachers would encounter in the school environment, including comorbidity issues for children with depression. Finally, the training session provided an opportunity for teachers to ask questions about students with depression and current school procedures to support this student population. As a result of the training, teachers reported greater confidence in their knowledge of mental health disorder. The teachers reported increased confidence in recognizing students in distress, as well as those exhibiting signs of mental health problems. However, teachers reported not feeling prepared to employ strategies to deescalate behaviors or refer students for services.

On the other hand, Kutcher and colleagues (2013) conducted a workshop model PD session with teachers where key findings indicated that teachers felt confident in responding to student mental health needs. In the current study, teachers were offered eight hours of PD about mental health disorder symptoms and classroom strategies. During the PD, the researchers presented information through such components as discussion and video clips. Participants completed a 30-item questionnaire pretest before the PD session to measure knowledge about mental health disorders. Likewise, participants completed a posttest immediately following the delivery of the training. The researchers completed a dependent t-test to determine if significant difference existed in teacher knowledge between pre and posttests. Results indicated that there was a significant increase in teacher mental health literacy. Teachers also reported feeling more confident in working with students with mental health problems.

Web-Based Models

Module-based training models aim to scaffold increased knowledge of symptoms for students with psychiatric disorders (Askell-Williams & Lawson, 2013). To investigate, Askell-Williams and Lawson (2013) studied the impact of KidsMatter Primary on elementary teachers' knowledge and pedagogy. KidsMatter Primary is a year-long multi-module whole school training program facilitated by a trained instructor. The intervention goal is to ensure that teachers' knowledge about learners with mental health needs is well structured and generative, to equip teachers to recognize and respond to externalized (e.g., acting out) behaviors, emotional distress, or signs of early emotional difficulty. The researchers relied on maximum variation sampling to include 100 schools that represented various locations (urban, suburban, and rural), sizes (small, medium, and large), and sectors (public, independent, and parochial). Before the KidsMatter implementation, teachers completed the Strengths and Difficulties Questionnaire (SDQ) to screen an at-risk students. Teachers also completed a seven-point Likert-scale questionnaire about content knowledge. The baseline data from the SDQ and teacher questionnaires revealed that approximately one-half of teachers did not know how to recognize disorder characteristics. Following the intervention, independent judgments by teachers about student mental health status concurred with students' scores on the SDQ 75% of the time. These findings suggest that teachers' knowledge of mental health disorder characteristics and symptomology increased throughout the training. Additionally, the study findings indicate that teachers felt more prepared and efficacious in addressing student needs.

Subsequently, Pereira et al., (2015) conducted a study to investigate an intensive three-week intervention for increasing knowledge of student mental health needs. The cluster-randomized, parallel group design compared two groups: (1)a control group using a web-based

intervention education (WBIE) group and, (2) a video-based education (TVBE) group. Interventions were implemented over three-weeks with teachers in nine urban elementary schools. The WBIE intervention program consisted of multiple components, including educational videos and interviews. The first two videos on the website provide basic information on symptomology, risk factors, and treatment options of various childhood psychiatric disorders, while the remaining provided information on classroom management strategies. The TVBE participants received a text-based tutorial with the same information as the WBIE group. Following the intervention, teachers completed a questionnaire about their knowledge and beliefs about student mental health. The authors analyzed the data using Mann-Whitney U and Chi-square tests to determine that teachers in the WBIE group had superior identification of mental health disorders, as well as reporting less-stigmatizing beliefs about mental health needs. While the study could not determine if teachers would increase helpful behaviors, such as making referrals to mental health services, the study found that teachers increased their knowledge of disorder symptoms.

While situated learning tenets suggest that teachers' classrooms are powerful contexts for learning it does not imply that PD should only occur in the teachers' setting (Borko, 2004). Online learning and interventions assist in building teacher efficacy in working with students with mental health needs. Long et al., (2018) evaluated the effectiveness of At Risk for Elementary School Educators*,* an online mental health role-play simulation PD tool. The virtual PD used principles of applied neuroscience, social cognition, and adult cognition to assist teachers in role-playing activities to recognize disorder behaviors and implement helping behaviors for students in distress. During the PD the teacher engages with a virtual student and parent who have emotions, personalities, memories, and reactions similar to those in a classroom

setting. The researchers recruited participants from 10 states, for a total sample of 18,896 participants. All participants completed baseline Gatekeeper Behavior Scales to measure attitude, self-efficacy, and preparedness, followed by the self-paced PD. Immediately following completion of the PD, teachers completed a post-simulation survey. Teachers reported that the PD was more effective than one-time workshops because it offered the opportunity to participate in more realistic situations that are often stressful in classroom settings; the PD provided teachers the opportunity to practice strategies in a low risk setting. Key findings revealed that participants felt better prepared and more efficacious in responding to student mental health crises in the classroom setting following the virtual PD.

Teacher Coaching

Current research suggests that while traditional PD sessions may increase knowledge about a specific subject, they do not give teachers the skills necessary to utilize skills and strategies presented in their own classrooms (Becker et al., 2013). Coaching provides guidance and ongoing support for teachers' pedagogical and behavioral skill development (Noell et al., 2005). Han and Weiss (2005) posit that teachers' successful experiences and feedback from coaches play a fundamental role in increased self-efficacy that may lead to further skill development. The coaching model reflects situated learning theory as it allows individuals to work together and engage in dialogue to develop their practice through building skills and strategies (Darling-Hammond & McLaughlin, 1995).

Although evidence-based practices exist to address externalized behaviors for students with mental health needs, promoting implementation in the classroom context remains challenging. In response to disruptive behaviors, schools often adopt social behavior models such as School-Wide Positive Behavior Interventions and Supports (SW-PBIS). SW-PBIS provides a

systematic process for teaching behavioral expectations to teachers in classroom and non-classroom settings within school or district settings (pbis.org). Although these behavior management systems provide behavior management support, often teachers are unsure of their ability to appropriately implement strategies to achieve the desired student outcomes (Reinke et al., 2011), suggesting that teachers are more likely to increase their self-efficacy when working with students with mental health issues, particularly externalized behaviors when offered coaching in the classroom setting (Rock et al., 2013; Stormont, Reinke, Herman, 2011).

Two researchers, Brock and Beaman-Diglia (2018), considered the impact of one-on-one modeling and coaching on teacher efficacy in implementing behavioral interventions for teachers working with students with severe psychiatric disorders. Specifically, the researchers aimed to understand if coaching would increase teachers' knowledge of strategies to use with students, as well as their self-efficacy in utilizing strategies with students in the classroom setting. The researchers collected baseline data through observation in the classroom before the intervention. Teachers received a 30-minute session to discuss an intervention strategy, which included a role-play and chance to ask questions. Two to three days after the intervention session, the researcher returned to provide feedback and answer questions. The researchers concluded that brief coaching sessions provide teachers without formal mental health training on evidence-based practice strategies, such as student visual aids and calm down strategies, that can be used in the classroom immediately. While the teachers noted that the unfavorable student behavior initially reduced but did not sustain, they felt the model was beneficial to implement strategies systematically. Additionally, the teachers noted that the training was helpful in that it was specific to their context and explicitly centered on an individual child's needs. However, the teachers expressed the need for ongoing support once the coaching sessions concluded.

Similarly, Capella et al., (2012) examined the effectiveness of coaching sessions delivered by community mental health professionals to increase teacher content knowledge of childhood psychiatric disorders and classroom strategies, to improve classroom practices to foster positive teacher-student relationships and student behavioral regulation. Specifically, the researchers implemented the BRIDGE coaching and consultation program, which embeds the intervention into regular classroom activities. Unlike most coaching programs, the BRIDGE program relies on mental health professionals utilizing standardized and validated tools, including the Classroom Assessment Scoring System (CLASS) to coach teachers to use target strategies. The study specifically included 12 mental health professionals who delivered the BRIDGE program and 36 general education elementary teachers receiving the coaching. The BRIDGE intervention cycle allowed for coaches and teachers to meet from January to April, having three to five consultation meetings, three to five observation meetings, as well as CLASS goal meetings. From these sessions, teachers reported increasing their knowledge of psychiatric symptoms and being able to respond to student needs. However, the study failed to establish changes in teacher behaviors.

While no specific consensus exists regarding the frequency and sequencing of coaching support necessary for teacher improvement, current research notes that it should include presentation of evidence-based activities, data collection, goal-setting, and performance feedback, regardless of the coaching and learning target (Becker et al., 2013). Reinke, Lewis-Palmer, and Merrell (2008) developed the Classroom Check-Up (CCU) model for teacher coaching and consultation, which helps teachers develop skills and strategies for working with children with disruptive behaviors. The authors' coaching model relies on assessing the current teacher practices through observation, interviews, and checklists; providing teacher feedback on

assessment findings; offering a menu of options to improve classroom outcomes that teachers and coaches create collaboratively; teachers chose interventions to implement, while the coach provides ongoing feedback; and teacher self-monitoring daily progress. The CCU model advantage includes the possibility of modifying the coaching process to fit each teacher's strengths and weaknesses, as well as include teachers in the development of the intervention. In this specific study, tailoring the coaching process to teacher needs decreased student disruptions and increased teacher self-efficacy in using specific strategies. In fact, teachers noted they would continue to use the classroom strategies because of the attention they received from the coaches and increased self-efficacy.

Support for Mental Health Teacher Professional Development

Mental health professional learning is multi-faceted and complex, thus should be approached thoughtfully to ensure engagement and knowledge uptake (Fortier et al., 2017). Educators need PD that allows for discussion of the needs of students with mental health, reflecting on classroom strategies, and the observation of experts modeling effective strategies (Fullan, 2002). A study by Sawka and colleagues (2002) showed results indicative of an increase in teacher self-efficacy in symptom recognition, as well as an increase in self-efficacy and ability to respond to student externalized behaviors. The authors suggest that an integrated teacher training model, which includes didactic and collaborative modules, effectively increases teacher knowledge and self-efficacy in intervening with students in distress. Specifically, the authors found that PD opportunities providing direct instruction, demonstration of skills and strategies, feedback, and collaborative discussions about the topic promote teacher success in managing symptoms and behaviors at school. The participants in the study included 64 teachers from 30 schools. The researchers based their training on the Strengthening Emotional Support Services

(SESS) program. The authors used the SESS program in modules for four days over three weeks. Following the modules, the teachers engaged in discussions and practice one day each week for 12 weeks. Overall, the results showed that the SESS training increased teacher knowledge of effective strategies for behavior management. However, the skills and strategies taught through the modules did not automatically generalize to teacher behavior. Modeling and collaboration of practical classroom strategies, however, did increase teacher ability and confidence in responding to disruptive behaviors.

Research conducted by Reinke et al., (2014) examined the effectiveness in teachers receiving the Incredible Years Teacher Classroom Management (IY TCM) intervention for working with students with mental health needs, specifically externalized behaviors. The training consisted of participating in small group intensive training for six full days by two IY TCM facilitators. Specifically, the intervention comprised of utilizing proactive teaching, praise and encouragement, incentives, and problem-solving strategies in the classroom setting. Each session relied on videos, role-playing, and the use of feedback from the facilitators. During the authors' study, 68 teachers and 1,148 students were recruited to test the effectiveness of the method. Teachers reported that the methods used increased their self-efficacy in working with students with mental health needs. Additionally, teacher reports and direct observations revealed that the intervention helped mitigate student disruptive behavior. Teachers also reported increased efficacy in implementing behavior management strategies with students. Practical implications showed that providing teachers with universal practices for all students and targeted supports for at-risk students simultaneously proved beneficial in the classroom context.

PD activities that are linked to teachers' experiences, promote professional discourse, and are aligned with other content efforts are essential in increasing teacher knowledge, efficacy, and

behavior change (Garet et al., 2001). Furthermore, PD design should focus on how teachers learn. Teachers learn by reading, watching, practicing, and reflecting, just as students do (Darling-Hammond & McLaughlin, 1995). Activities that allow for information presentation, active learning, modeling, practice, and feedback encourage teachers to transform their teaching practices, rather than "layer new strategies on top of old" (Darling-Hammond & Richardson, 2009, p. 48).

Implications and Conclusion

Elementary teachers report having limited knowledge and self-efficacy when working with students returning to school following psychiatric hospitalization (Clemens et al., 2010). Many research studies show that this is due, in part, to insufficient training in student mental health (e.g., Reinke et al., 2011; Rothi et al., 2008; Savina et al., 2014; Simon & Savina, 2010), suggesting that high-quality PD would be beneficial in supporting teachers in working with students with mental health needs (Askell-Williams & Lawson, 2013).

While this is true, some PD is more effective than others. A review of the literature suggested that teachers should gain a greater understanding of mental health disorder symptomology to recognize students in distress and make appropriate referrals for support (Fortier et al., 2017). Furthermore, PD should offer strategies for teachers to use when a student is experiencing externalized or internalized behaviors (Kutcher et al., 2013). Additionally, PD should feature several key components, such as active learning and extended duration, to ensure teachers acquire the mental health content necessary to recognize and respond to student needs. As situated learning theory guided the literature review, collaboration and authentic learning experiences within context also played a critical role in characterizing high-quality PD (Lave & Wegner, 1991). Empirical studies confirmed that team collaboration models have a positive

impact on improving teacher knowledge and efficacy when working with students with mental health needs and those returning to the classroom (Sawka et al., 2002).

Therefore, findings from both the literature and the empirical needs assessment suggest that teachers would benefit from PD that includes opportunities for knowledge acquisition about mental health symptoms, as well as skills and strategies to use in the classroom setting. While the dissertation focuses on creating successful reintegration for elementary students returning to school following psychiatric hospitalization as a distal outcome, increasing teacher knowledge of mental health disorders, as well as self-efficacy in responding to students' needs is the short-term goal for the current study.

Accordingly, this researcher recommended a mental health intervention, providing opportunities for teachers to learn through face-to-face PD sessions, as well as practice strategies in their respective classrooms between sessions. However, mandatory school closures related to the coronavirus (COVID-19) removed face-to-face PD options. While this is true, current literature presented in this chapter indicated the effectiveness of web-based PD models in increasing teachers' knowledge of student mental health disorder symptoms and confidence in addressing student needs in the classroom (e.g., Pereira et al.,2015). As such, the study intervention includes active learning and collaboration, allowing teachers to learn through modeling, practice, and feedback (Chaaban, 2017; Clemens et al., 2011; Darling-Hammond & Richardson, 2009). The next chapter delineates the essential content and components of a mental health PD intervention for teachers, as well as the process for evaluating the implementation and outcomes.

CHAPTER FOUR

Intervention and Research Design

Current literature about interventions that increase the successfulness of students reintegrating into school after psychiatric hospitalization indicate that elementary teachers benefit from high-quality PD about mental health disorder symptomology and classroom behavioral and instructional strategies (Reinke et al., 2011; Rothi et al., 2008). The key needs assessment findings presented in chapter two corroborate this literature, as teachers noted that they lack knowledge and strategies to work effectively with children with mental health needs. Furthermore, teachers reported needing PD to learn to recognize and respond to students' mental health symptoms. Providing PD learning experiences would improve teachers' knowledge and self-efficacy in working with students with mental health issues, particularly those returning to school after hospitalization. As such, the purpose of this chapter is to describe the theoretical underpinnings and components of a PD program in mental health disorder symptoms and classroom strategies within the context of a suburban Midwest public school district. This chapter also delineates the methodology related to process and outcome evaluations of the program implementation. Along with this, the chapter will describe the strengths and limitations of the study.

Purpose of Study

Chapter Three identified the elements of high-quality and effective PD, as well as presented the results from multiple studies on the effect of teachers' knowledge of mental health symptoms, use of classroom strategies, and cultural awareness when working with students with mental health issues. With that in mind, the literature indicated that single-session workshops are the most common form of PD for elementary teachers; however, effective PD requires sustained,

content focused, and contextually relevant learning (Desimone, 2009; Jensen et al., 2016). Furthermore, literature indicated that collaborative PD opportunities that provided social interactions and active learning enhanced teacher learning (Borko, 2004; Desimone, 2009). When considering teacher PD for mental health literacy, programs that included these elements evidenced greater teacher knowledge and self-efficacy in accurately recognizing student symptoms (e.g., Sawka et al., 2002) and increased self-efficacy in utilizing behavioral strategies for students exhibiting distress and other mental health concerns (e.g., Reinke et al., 2014). Knowledge of mental health symptoms influenced teacher support and preparedness in intentionally developing a plan to work with mental health providers and families in transferring students' treatment gains in the classroom setting (Clemens et al., 2011)

The needs assessment indicated that teachers did not feel efficacious in recognizing or responding to student mental health needs in classroom settings. Focus group participants reported that their low self-efficacy in working with students limited their practice of making mental health referrals or addressing behaviors in the classroom. Similarly, teachers reported the desire to learn more about student mental health and classroom behavioral strategies, particularly for externalized behaviors. In light of these findings, a PD intervention was implemented to develop teacher knowledge, teacher self-efficacy, and teacher use of research-based strategies in working with students with mental health disorders over a period of six months. As such, the purpose of the study was to evaluate the effectiveness of an intervention consisting of didactic and collaborative PD sessions on recognizing the symptoms of common childhood mental health disorders and using behavioral strategies to respond to mental health symptoms in the classroom. The distal goal of increasing teacher knowledge and self-efficacy in working with students with mental health disorders was increasing the successfulness of student reintegration following

psychiatric hospitalization. Current literature confirmed that teachers require the knowledge and confidence to identify symptoms, as well as use classroom strategies to support students' academic, social, and behavioral functioning to facilitate successful reentry (Clemens 2010, 2011; Preyde et al., 2017; Simon & Savina, 2005, 2010.

Briefly, the intervention provided PD through didactic and collaborative formats, which relied on active and social learning. The PD activities included discourse, parent panels, strategy modeling, and teacher collaboration about student mental health disorders and classroom strategies. Later sections of this dissertation provide a detailed description and explanation of the intervention activities.

Research Questions

Process evaluations allow researchers to gain a better understanding of the relationship between an intervention and outcomes (Saunders et al., 2015). Outcome evaluations, on the other hand, provide insight into the extent to which proximal, intermediate, and distal outcomes were achieved because of the intervention (Creswell and Plano Clark, 2018). Both outcome and process evaluation questions guided the current study. The guiding questions are listed below.

- Process evaluation question one: What proportion of the target population participated in each PD session?
- Process evaluation question two: To what extent were the learning objectives met each PD session?
- Outcome evaluation question one: To what extent did the participation in the PD sessions influence teacher knowledge of childhood mental disorders symptoms and signs of student distress?

- Outcome evaluation question two: To what extent did participation in the PD sessions influence teachers' self-efficacy in recognizing and responding to childhood mental health disorders and signs of student distress?

The hypotheses for the research questions were that the PD intervention will lead to proximal outcomes, including increasing teacher knowledge of mental health disorder symptoms, developing an understanding of effective strategies to use with students in the classroom, and increasing teacher self-efficacy when responding to students' mental health needs. Furthermore, increasing teacher knowledge and self-efficacy would prepare teachers to utilize strategies to respond to students presenting mental health symptoms in school settings. The distal outcome of the intervention included increased successfulness of elementary students reintegrating into the school and classroom environments following psychiatric hospitalization. Because of time constraints, the outcomes related to the distal goal were not studied.

Research Design

The research design, a convergent parallel mixed methods design, provided an opportunity to obtain both quantitative and qualitative data to develop and expand an understanding of the intervention outcomes (Creswell & Plano Clark, 2018). Utilizing quantitative and qualitative data provided a systematic approach to integrating multiple types of data that leads to an integrated set of inferences (Tashakkori & Teddlie, 2003). With that in mind, simultaneous data collection served to confirm "a quantitatively derived hypothesis and explore in greater depth the processes by which the relationship occurred" (Teddlie & Tashakkori, 2003, p. 16). According to Johnson and Onwuegbuzie (2004), mixed methods research is "the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts, or language into a single study"

(p. 17). This specific research design allowed quantitative and qualitative data to be compared and considered where results converged or diverged (Creswell & Plano Clark, 2018). A convergent parallel design provided equal importance to quantitative and qualitative data so to understand the influence of the collaborative PD on elementary teachers' knowledge and self-efficacy when working with students with mental health needs.

Process Evaluation Design

Process evaluation provided an opportunity to monitor intervention implementation, as well as understand the relationship to look inside the "black box" (Saunders et al., 2015). Process evaluation took place for multiple reasons, including to investigate factors related to how an intervention was implemented and received by the participants (Baranowski & Stables, 2000). Similarly, process evaluations provided insight into evaluation validity, which fostered program improvement (Rossi et al., 2004).

A mixed methods approach to process evaluation helped determine whether the training was implemented with fidelity. Implementation fidelity was defined as the extent to which the intervention was implemented as designed (Dusenbury et al., 2003). Dusenbury and colleagues (2003) suggest that several components, including program adherence and dosage, influence fidelity. Implementation fidelity was the key construct that guided the process evaluation questions for the PD intervention. For this study, quantitative and qualitative data examined dose and adherence to assess implementation fidelity. Specifically, the number of contact hours as measured by attendance provided information about dosage. Additionally, quality of programming was determined by the extent that learning objectives were met each session. Table 7 shows the specific indicators for the process evaluation.

Table 7

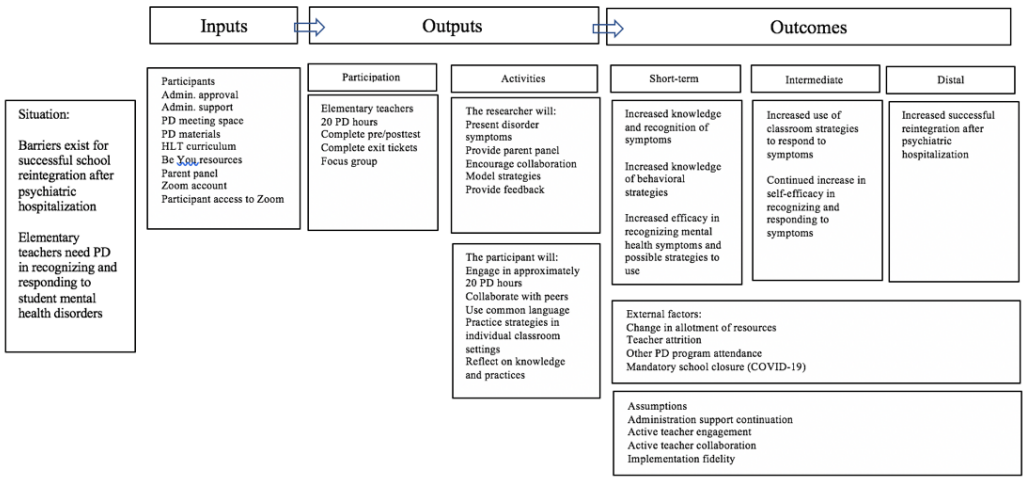
Process Evaluation Indicators

Process Evaluation Questions	Process Evaluation Indicators	Data Source	Data Collection Tool	Frequency	Who	Data Analysis
What proportion of the target population participated in each professional learning session?	Attendance	Elementary teachers	Attendance log	Each PD session	Participants will sign in at each session	Descriptive statistics
To what extent were learning objectives met in each session?	Participant perceptions about topics covered in each PD session	Elementary teachers	Open-ended exit tickets Semi-structured focus group interview	Each PD session End of intervention	Teachers will complete exit tickets each session Researcher will conduct focus groups in the spring of 2020	First and Second coding process (Miles et al., 2013) Emergent coding

Figure 3 shows the logic model for the intervention. The logic models guided the study and evaluation by identifying key intervention components, as well as conveying how these components related to each other to meet short-term, intermediate, and distal outcomes (Cooksy et al, 2001).

Figure 3.

Intervention Logic Model



Dose

Dose can be defined as the duration and intensity of program content received by research participants (Dusenbury et al., 2003). In this study, dose indicated the completeness of the progress delivered by the instructor and the exposure to content by the participants (Saunders et al., 2005). Completeness of the PD sessions was essential for understanding mental health symptoms and behavioral management in classroom environments, as presented through PD sessions, which utilized a modified version of The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (HLT; Wolpow et al., 2016) program.

Current research in PD suggests that approximately 20 contact hours are needed for effective intervention implementation and professional learning (Desimone, 2009; Swan- Dagan & Bean, 2014; Yoon et al., 2007). As such, the PD intervention included monthly PD sessions, from January through June 2020. Specifically, the program included six 2.5-hour sessions each month during the second semester of the 2019-2020 school year. During the January and February sessions, the teachers also practiced strategies for recognizing and responding to

student mental health symptoms they learned in the PD sessions in their individual classrooms. After February the participants were no longer able to practice strategies in their classrooms due to mandatory school closures due to COVID-19. Additionally, at this time, the intervention format changed from in-person PD sessions to online sessions. Taken together, teachers participated in approximately 15 contact hours during the six-month duration of the intervention, as well as any additional hours spent practicing classroom strategies before the mandatory school closures. Taken together, teachers participated in approximately 18 hours of PD during the intervention.

Program Adherence

Effective implementation ensures that planned activities and components of a program are carried out during an intervention, as well as participants' acceptance and participation in their roles (Zhang et al., 2011). The PD activities and teacher collaboration conducted over the course of the intervention offered information about adherence, focusing on the extent to which learning objectives were met each session.

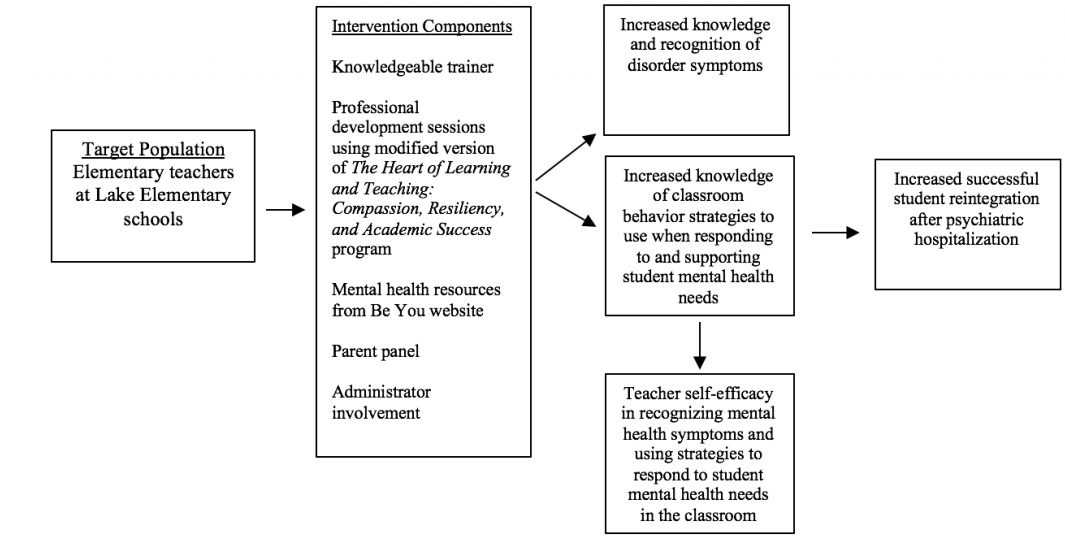
In this study, the learning objectives focused on participants' understanding descriptions of different mental health disorders, recognizing symptoms of a variety of mental health disorders, and understanding when and how to respond to student symptoms of mental health disorders. Participants reported information at the conclusion of each session indicating the extent to which learning objectives were met. Specifically, at the end of each session, participants completed an exit ticket, or a short formative assessment tool, sharing what they learned and the extent to which the session objectives were met.

Outcome Evaluation

Outcome evaluation provided data about the proximal, intermediate, and distal outcomes achieved because of the intervention (Creswell and Plano Clark, 2018). The theory of treatment (ToT) highlighted the processes of the intervention that produced the intended outcomes (Leviton & Lipsey, 2007). Teachers often feel unable to recognize mental health symptoms (Reinke et al., 2011) and have low self-efficacy in teaching students with mental health needs (Frauenholtz et al., 2017; Simon & Savina, 2010). Addressing limited knowledge and self-efficacy was possible through teacher PD opportunities (Desimone, 2009; Little, 1999). Figure 4 shows the study's theory of treatment diagram which represented the study's identified outcomes.

Figure 4

Theory of Treatment for the Intervention



According to the theory of treatment diagram, the intervention was expected to increase participants' knowledge of mental health disorder symptoms and classroom strategies for working with students with mental health problems, as well as increase teacher self-efficacy in

using strategies to respond to student needs. According to the ToT and logic model, such proximal outcomes lead to intermediate outcomes of increased teacher self-efficacy in recognizing and responding to student mental health needs in classroom settings. Due to the brief duration of the intervention study, the distal outcome of increased successfulness in student reintegration into classroom and school environments following psychiatric hospitalization was not measured. With that in mind, the proximal and intermediate outcomes were measured and used to determine the effectiveness of the PD intervention.

This specific intervention and outcome evaluation relied on a non-experimental design. Due to the intervention taking place outside of school hours and the small sample size, the study was a treatment only study and did not include randomization or a control group (Shadish et al., 2002). Study participants completed pre-and posttest surveys to provide information about their knowledge of childhood mental health symptoms and self-efficacy in recognizing and responding to student mental health needs. A pre- and posttest design measures the amount of learning over the course of the PD intervention (Rossi et al., 2004). Specifically, the participants completed the Elementary Mental Health Survey, which consisted of the Mental Health Literacy Scale (MHLS; O'Connor & Casey, 2015), as well as two subscales of the Teacher Efficacy for Inclusive Practices scale (TEIP; Sharma et al., 2012). Participants completed the survey before the PD sessions began, as well as at the conclusion of the research study. The MHLS measured teacher mental health knowledge, while the TEIP assessed teacher efficacy of teaching students with mental health needs section of the survey. These scales are described in more detail in the measures and instrumentation section of this chapter.

Furthermore, upon completion of professional learning sessions, the researcher elicited teacher participation in semi-structured focus group interviews. The focus group interview

allowed for data collection about the extent to which teachers' self-efficacy increased through the intervention. During the focus group, the researcher asked questions about knowledge acquisition as well.

Strengths and Limitations

Inherent strengths and limitations existed in this study. The convergent parallel mixed method design compared quantitative and qualitative datasets to gain a deeper understanding of the results. Specifically, the design offered qualitative data to help corroborate quantitative findings from the MHLS and TEIP. Quantitative data often lacks contextual information surrounding data collection and analysis, while qualitative data may include biases and limited generalizability (Lochmiller & Lester, 2017). This mixed methods design offset these weaknesses by offering exploration and analysis of both datasets within the same study. Likewise, a mixed method design also mitigated construct threats to validity by relying on more than one method, such as self-reports (Shadish et al., 2002).

Threats to validity existed in this research study. For example, because of the sensitive topic of mental health disorders, participants may have provided socially appropriate answers on the survey or during focus groups rather than express personal beliefs. Reactivity to the experimental situation includes participants attempting to guess what the researcher is studying and provide acceptable answers (Shadish et al., 2002). Although the researcher attempted to mitigate reactivity by stressing confidentiality, it is impossible to eliminate participants' reactions and attempts to be socially acceptable in their self-reported answers (Shadish et al., 2002). Similarly, the study relied on a small sample size, as only nine participants completed the full intervention. Due to the sample size, results could not be generalized to the entire population of elementary teachers in the district.

Methods

The context of the study was a suburban public-school district in a Midwestern state. The district served approximately 6,230 students. At the time of the study, the district employed 168 certified elementary teachers. This study collected data from certified elementary teachers working in general and special education, although specialist teachers and interventionists were invited to participate.

Participants

Certified elementary teachers in the district represented general and special education classrooms from pre-kindergarten through fifth grade, across seven elementary schools. Of these district employees, ten elementary certified teachers agreed to participate in the student mental health intervention PD sessions. The researcher confirmed participants' participation eligibility by referencing the state's Online Educator Certification System. This system provides access to a web-based system that allows district employees to ascertain information about teacher certification and endorsements. According to the state system, all ten participants held current state elementary teacher certifications. Furthermore, information reported in in the certification system indicated that three of the participants also had special education endorsements.

Eight of the ten participants were female, while two were male. Similarly, eight participants held full-time employment status, whereas two taught half-time. Most participants taught in general education settings, ranging from kindergarten through grade five; however, two teachers had special education placements. No specialist teachers or interventionists participated in the study. When considering educational attainment, five participants held Bachelor's degrees and five held Master's degrees.

As the researcher was an elementary educator, the participants were colleagues within the school and across the district. Having equivalent positions within the district, the researcher had no authority over participants, mitigating possible coercion. To further avoid undue influence, participants were required to give consent before participating in the intervention, completing the survey, and taking part in the focus group. In the intervention, consent clearly stated that participants might choose to drop out of the study at any time. Attrition refers to the reality that sometimes study participants fail to complete the full intervention (Shadish et al., 2002). In the current study, due to the COVID-19 pandemic, one participant dropped out of the study after the second PD session, leaving nine participants who completed the entire intervention. At the completion of the PD intervention, the researcher conducted a focus group to collect information about the process and outcome evaluation questions.

Measures and Instrumentation

This section describes the specific quantitative and qualitative measurement tools used in the process and outcome evaluation to answer the study research questions. Outcome evaluation tools included surveys to measure teacher mental health knowledge, as well as teacher-self efficacy for working with students with mental health disorders. Additionally, a semi-structured focus group interview provided information about teachers' participation and implementation, along with teachers' ability to recognize and respond to student mental health needs using strategies presented through the PD sessions. Table 8 summarizes the specific variables and measures that were used in this study.

Table 8

Mixed Methods Measures

Measure	Quantitative	Qualitative	Data Collection Type
Attendance Log	X		Self-report of attendance & contact hours
Session Exit-tickets		X	Self-report of PD experiences
Semi-structured focus group interview		X	Self-report of learning and PD experiences
Elementary Mental Health Survey (MHLS & TEIP subscales)	X		Self-report survey of mental health knowledge, self-efficacy

The purpose of administering the pre and posttest mental health survey was to measure changes in teacher knowledge about symptoms related to childhood mental health disorders and use of strategies to respond to student mental health symptoms. Furthermore, qualitative focus groups offered rich insight into teachers' experiences with working with students with mental health disorders, such as recognizing and responding to their needs.

As aforementioned, a convergent parallel mixed methods design merged quantitative and qualitative data to explain converging and diverging data from the study. Therefore, the semi-structured qualitative interview conducted at the conclusion of the study were used to compliment quantitative findings from the process and outcome evaluations.

Attendance Log

Obtaining participant attendance records helped answer the process evaluation question about what proportion of the target population participated in each PD intervention session. Monitoring participant attendance clarified the extent to which teachers received information and strategies for working with students with psychiatric disorders. Additionally, tracking attendance helped ensure that sufficient numbers of participants were being reached (Saunders et al., 2005). For the January and February face to face sessions the attendance sign-in sheet was utilized to collect teacher attendance data. Due to COVID-19, which necessitated that the sessions moved from in-person PD to an online format, Google Forms sign-ins were used to collect attendance information for the remaining sessions.

Session Exit Tickets

Each session included an exit ticket that collected teachers' learning and reflection for the content covered. The exit tickets asked questions about teachers' perceptions about the extent to which learning objectives were met for each session, as well as how the session information aligned with their beliefs and would influence their classroom experiences. Similarly, the exit tickets asked the participants about the knowledge gained from the session, their self-efficacy in recognizing symptoms in a classroom setting, and their self-efficacy in utilizing strategies in their classrooms. The exit ticket questions were connected to the study's research and evaluation questions. Sample questions include:

1. What do you know about student mental health now that you didn't know before the session?
2. What questions do you still have about mental health disorders after today's session?

The PD plan (Appendix C) presents the exit ticket questions specific to each PD session.

Semi-structured Focus Group Interview

The researcher conducted a semi-structured focus group interview at the conclusion of the six-month intervention. Teachers were invited to participate in the focus group to answer questions regarding the information and strategies that they found helpful or beneficial for working with students with mental health needs. The focus group allowed the researcher to collect qualitative data on the process and outcomes of the student mental health PD intervention. With that in mind, the focus group provided an opportunity for participants to discuss their knowledge of student mental health disorders, including their ability to recognize disorder symptoms, while also serving as a process evaluation measure.

Specifically, the focus group participants were asked questions regarding the information and strategies that they found helpful or beneficial for working with students with mental health needs. Sample focus group questions included:

1. I'd like to talk about your experience in the PD sessions. What information or activity did you benefit from the most during the PD sessions?
2. I am wondering how the sessions influenced your knowledge and efficacy in meeting student mental health needs. What role, if any, do you believe the sessions played in influencing your knowledge? Efficacy?

The responses collected during focus group interviews offered important qualitative information about the quality of the PD intervention program in increasing knowledge of mental health symptoms and the use of effective strategies to recognize and respond to student mental health needs.

Furthermore, current literature showed that semi-structured focus group interviews have been used to collect data about teachers' student mental health knowledge to determine teachers'

mental health knowledge and self-efficacy (Askell-Williams, 2013; King et al., 2014). Interview questions from these studies focused on changes in understanding mental health symptoms and their ability to recognize struggling students. Likewise, interview questions also focused on teachers' perceived ability to teach students with mental health symptoms. Focus group interview questions were adapted from current studies. Sample questions included:

1. Talk about how your current ability to notice student mental health needs in your classroom compared to your ability before participating in the PD program.
2. How confident do you feel in recognizing different mental health disorders? How confident are you in responding to students' symptoms?
3. What information do you still need to learn to feel confident in working with students with mental health disorders?

Furthermore, the focus group centered on teachers' self-efficacy in using strategies for responding to student mental health needs in the classroom. The strategies included responding to a student in distress, as well as strategies to deescalate externalized behaviors. See Appendix D for a list of all of the process and evaluation focus group questions asked during the interview.

Because of the inability to meet in-person due to school closures, the PD participants met online for the interview using Zoom. The Zoom focus group session was not recorded. However, the researcher audio recorded the focus group interview from a mobile phone using the Rev voice recorder app. Audio recordings of focus group interviews afforded the researcher the opportunity to transcribe the participants' responses verbatim (Lochmiller & Lester, 2017). Rev provides online services platforms for accurate recording and transcription services, guaranteed by enterprise-grade security and data encryption. Following the recording, the researcher

submitted the audio file to Rev for transcription services. To ensure anonymity, the researcher required that participants' names were not included in the transcription.

Elementary Mental Health Survey

Study participants completed two mental health scales as part of a quantitative pre and posttest. Teachers completed the MHLS (O'Connor & Casey, 2015) and two subscales of the TEIP (Sharma et al., 2012). The scales comprising this survey can be found in Appendix E.

Mental Health Literacy Scale. The MHLS (O'Connor & Casey, 2015) measured elementary teachers' knowledge of mental health disorder symptomology. Specifically, the scale measured the ability to recognize symptoms related to mental health disorders, as well as knowledge of risk factors of mental health problems and knowledge of how to seek information. The MHLS asked teachers to read symptoms and determine what disorders they represent. Additionally, the survey asked teachers to determine what tools were helpful to mitigate symptoms of mental health disorders.

The MHLS included 25 Likert-type questions focused on six sub-dimensions. The six sub-dimensions of mental health knowledge included: (a) ability to recognize certain disorders, (b) knowledge of how to seek mental health information, (c) risk factors and causes, (d) knowledge of self-treatments, (e) knowledge of professional help available, (f) attitudes that promote recognition and appropriate help-seeking. The ability to recognize mental health disorders sub-dimension focused on knowledge related to common mental health disorders. Descriptions of the disorders are based on those given by the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5). The knowledge of how to seek mental health information and attitudes that promote recognition and appropriate help-seeking sub-dimension questions sought to understand the respondents' capability and attitudes toward seeking and

accessing mental health information. Questions regarding risk factors and causes assessed knowledge of risk factors for developing mental health disorders. Likewise, the questions also assessed knowledge of common misconceptions about developing mental health disorders. The final two sub-dimensions, knowledge of self-treatments and knowledge of professional help available, included questions about strategies recommended by mental health professionals to improve mental health and wellbeing.

Results of O'Connor and Casey's (2015) analysis showed that the MHLS is valid and reliable to identify and evaluate the acquisition of mental health literacy. Specifically, the authors note that the scale has a Cronbach's alpha of .87, indicating high internal consistency. The authors suggest that the instrument allows the opportunity for the assessment of an individual's mental health literacy, for example in use by policy makers to measure trends in mental health literacy; and develop appropriate interventions. A limitation for the survey is that it was not developed specifically for teachers.

Teacher Efficacy for Inclusive Practices. The TEIP (Sharma et al., 2012) measured teacher efficacy in providing inclusive instructional practices, collaboration, and managing behaviors. For the purposes of the current study, only two sub-dimensions of the TEIP were used: (a) self-efficacy in collaboration and (b) managing behavior. Specifically, these sub-dimensions were used to measure teachers' self-efficacy in working with others to assist students with mental health needs in the classroom and responding to externalized and internalized classroom behaviors. The self-efficacy in collaboration included five Likert-type questions. Specifically, the questions assessed teachers' ability to work with school staff and parents to meet students' needs in the classroom setting. The managing behaviors sub-dimension consisted of 15 Likert-style questions regarding teachers' self-efficacy in recognizing student mental

health problems, intervening when a student exhibits signs of distress, and utilizing classroom strategies to prevent or respond to student mental health needs. The TEIP was timely as it reflected teachers' perceived preparedness and self-efficacy in working with students in inclusive settings. The Cronbach's alpha for the total score is 0.89, suggesting that the scale provides a reliable measure of teachers' self-efficacy in working with students with mental health needs.

Study Procedure

This section provides an in-depth description of the intervention timeline and sessions, including the mental health disorder information and activities. It also includes an overview of the data collection and analysis process.

Professional Development Intervention

The monthly mental health PD sessions consisted of two main components: (a) mental health disorders description and symptomology, (b) classroom strategy modeling and participant practice. The intervention originally included a third component, classroom practice between PD sessions; however, with mandatory school closures in the spring of 2020, teachers did not have the opportunity to practice strategies in the natural context of their classroom with students for the majority of the intervention. Specifically, teachers engaged in classroom practice in January and February only. Table 9 shows a specific timeline of PD sessions and topics covered during each session.

Table 9

Professional Development Timeline and Topics

Date	Session	Length	Topic
January 2020	1	2.5 hours	Depressive disorders
February 2020	2	2.5 hours	Anxiety Disorders
March 2020	3	2.5 hours	Post-Traumatic Stress Disorder
April 2020	4	2.5 hours	Conduct Disorders
May 2020	5	2.5 hours	Attention Deficit Hyperactivity Disorder
June 2020	6	2.5 hours	Obsessive Compulsive Disorder

Due to district policies and pre-determined agendas for district provided PD days, the school district required the study intervention to take place outside of school hours. As such, the intervention took place one afternoon each month, directly following the end of the contractual school day. During January and February, the PD sessions took place in the library of the researcher's school. After an executive order from the state governor issuing mandatory school closures of all school in the state due to COVID-19, the PD sessions continued to take place outside of school hours using Zoom.

Participant Recruitment

According to Creswell and Plano Cark (2018), to answer a research question, the researcher must engage in a sampling procedure to determine the participants who will provide data in the study. This study relied on nonprobabilistic sampling, which involved selecting individuals who were available to be studied (Lochmiller & Lester, 2017). Participant eligibility criteria included

all teachers in Lake Public Schools, a pseudonym, holding a current state teaching certificate with an elementary endorsement. With that in mind, all general education, special education, and specialist teachers in the district were eligible to participate in the current study. As such, the researcher invited all certified elementary teachers in the district to participate because of availability; however, nonprobabilistic sampling does not allow the researcher to suggest that the sample is representative of all teachers (Creswell & Plano Clark, 2018).

The recruitment process began in November 2019. Specifically, the researcher sent a recruitment email to 168 certified teachers' district provided email address providing an overview of the mental health PD intervention. The overview included information about the purpose, format, and benefits of the research study. Additionally, the researcher provided a study flyer with information about the study session topics, dates and times of sessions, and contact information. The researcher posted a copy of the flyer in each school's lounge area. Following this information, teachers were invited to contact the researcher via email or phone to ask questions about the study or to sign a consent form to officially participate in the study. The consent form outlined the data collection procedures, as well as confidentiality.

From the study recruitment, eight elementary teachers agreed to participate. According to O'Leary (2014), when working with quantitative data, statistical analyses require a minimum of approximately 30 respondents. With this in mind, a second recruitment effort was conducted. Certified elementary teachers in the district received the recruitment email and flyer a second time. The second round of recruitment efforts resulted in two additional teachers consenting to participate in the study.

Therefore, 10 participants consented for the study. To ensure anonymity, each participant was referred to as participant one through ten in data collection and analysis. While one participant

dropped during the study due to the COVID-19 pandemic, participants retained these study reference names for consistency. However, no data from Participant Six was included in the analysis beyond the pretest. Furthermore, the participant dropping from the study resulted in a total of nine participants who completed the entire study. As such, the study's response rate dropped to .053%.

Professional Development Sessions

The participants in the intervention attended two in-person PD sessions, as well as four virtual sessions between January 2020 and June 2020. The PD sessions were based on two existing mental health curriculums, the Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (HLT; (Wolpow et al., 2016) and Be You programs (Australian Government National Support for Child and Youth Mental Health Program, 2019). These programs detailed below.

Intervention Programs

Each PD session consisted of teacher discussion and reflection, mental health disorder information, including symptoms and risk factors, and classroom strategies. Two primary programs informed these PD session components. Specifically, the HLT (Wolpow et al., 2016) and Be You programs (Australian Government National Support for Child and Youth Mental Health Program, 2019) were used to create session content and activities. Be You modules were used to inform participants about symptoms, aiming to increase teacher knowledge of mental health disorders. The HLT curriculum provided strategies for teachers to use to respond to symptoms and behaviors in the classroom setting. The components from each program are described below.

The current study incorporated information and resources from the Be You program (Australian Government National Support for Child and Youth Mental Health Program, 2019). Be You is an open-access program based on Bronfenbrenner's (1979) EST model, aiming to help educators develop an understanding of how a child's environment affects mental health symptoms and support. Be You provides educators with information about childhood mental health disorders to help teachers develop a better understanding of disorder prevalence and symptom recognition. Specifically, Be You presents this information through videos, online modules, and resources, such as fact sheets about student mental health. The online modules addressed risk and protective factors, symptoms, and teachers' roles in helping students with mental health. Additionally, the Be You program offered guidelines on how to approach school staff and families for referring students for mental health supports.

From the Be You program, this study relied specifically on information and resources from the Understanding module from the Mentally Healthy Communities, Early Support, and Responding Together programs. The researcher used mental health disorder information including symptomology, risk and protective factors, and social and academic indications of mental health crises from these modules to create PD session activities.

The PD program also included a modified version of HLT curriculum (Wolpow et al., 2016) to guide the learning sessions. The HLT program presents classroom strategies to help teachers develop compassionate instructional and disciplinary practices for students with mental health disorders in the classroom. Specifically, the program is based on six principles: (a) always empower, never disempower, (b) provide unconditional support, (c) maintain high expectations, (d) check assumptions, observe, and question, (e) be a relationship coach, and (f) provide guided opportunities for helpful participation. These six principles guide the program's classroom

strategies for working with students with mental health needs. Additionally, these six principles were embedded in three domains. The domains include: (a) safety, (b) emotional and behavioral regulation, and (c) personal competencies. With this in mind, the HLT curriculum focused on these six principles and domains to promote the awareness that mental health symptoms are not intentional misbehavior, yet require teachers to develop empathetic assertiveness to respond to internalized and externalized behaviors.

For each domain, the HLT program included classroom strategies for responding to student needs, including emotion identification, trigger reduction, and self-regulation. During the PD sessions, classroom strategies were modeled for the participants. Participants also engaged in practicing strategies, as well as received feedback from the researcher and each other. Similarly, participants had the opportunity to collaborate and discuss how to adapt strategies to meet the needs of students at different grade levels and in different situations.

For the purpose of this study, the researcher did not use chapter two of the program, which focused on teacher self-care for working with students with mental health disorders. Additionally, the PD sessions did not include content about community connections from chapter five. The researcher omitted these chapters from the current study because they did not directly relate to recognizing and responding to student mental health symptoms in the classroom.

Mental Health Disorder Symptom Content. The first half of each session focused on understanding and recognizing the symptoms of various mental health disorders. Each session was dedicated to one disorder. The six sessions focused on the following mental health disorders, respectively: (a) depressive disorders, (b) anxiety disorders, (c) trauma, (d) conduct disorders, (e) attention deficit attention disorders, and (f) obsessive-compulsive disorder.

To teach participants how to recognize the symptoms related to these disorders, the researcher relied on active learning. For example, participants completed the Be You notice modules in partners through a gallery walk. A gallery walk is a collaborative activity in which learners work in teams to answer questions posed by the instructor at different stations. At each station, the teams review what previous groups have written and then add their own insights and new content (Edutopia, 2016). Furthermore, the researcher utilized Be You video resources to discuss teachers' roles in understanding, recognizing, and responding to mental health symptoms during the PD sessions. The videos, developed as part of the Be You program, were taken from the Mentally Healthy communities, Early Support, and Responding Together modules (Australian Government National Support for Child and Youth Mental Health Program, 2019). Each video presented information about risk factors and symptoms. Using the information from these modules, participants created disorder flipbooks, or short booklets of key symptoms to identify and recognize with each of the various disorders. Teachers created flipbooks with disorder symptoms to refer back to in the future. Along with activities, they practiced recognizing different mental health disorder symptoms through the use of role playing and vignettes. The researcher incorporated vignettes from HLT for teachers to practice recognizing symptom differences between disorders that students might present in classroom settings. Refer to Appendix L for specific content, learning activities, and exit ticket questions for each PD session.

Although the intervention moved to an online platform starting in March, the researcher utilized Zoom's collaboration tools to ensure active learning, which is shown to be a necessary component of effective PD (Darling-Hammond & Richardson, 2009; Jensen et al., 2016;

Learning Forward, 2011). Specifically, the activities described above were conducted using virtual breakout rooms, simultaneous screen sharing, polls, and whiteboard annotating.

Classroom Strategies. Along with information related to disorders, the intervention consisted of classroom strategies to help prepare teachers to respond to mental health symptoms in classrooms. Classroom strategies to support students exhibiting mental health symptoms were modeled and practiced during the second half of each session. For suggestions of classroom strategies, the researcher primarily used those from the HLT curriculum.

The HLT classroom strategies were presented through the program's three domains listed above. The first domain is safety. With this in mind, PD sessions included classroom strategies from the safety domain, including such strategies as calming corners. Second, from the emotional and behavioral regulation domain, the PD sessions included strategies such as developing precise emotional vocabulary. Finally, nonviolent communication strategies were modeled and practiced to support domain three, personal competencies. Along with these strategies from HLT, the intervention included classroom games to support positive mental health and calming activities.

These strategies were modeled by the researcher, then practiced by the participants. Using Zoom, the teachers joined in role playing activities and practiced using strategies in breakout rooms. Along with this, teachers had opportunities to collaborate with participants in similar grade levels to adapt strategies to meet their students' developmental needs. Likewise, participants collaborated with others of similar grade levels to develop ways to incorporate strategies into current school policies and instructional expectations. For example, teachers worked together to integrate precise emotional vocabulary during reading workshop, using the district's reading curriculum.

During the last session, participants had the opportunity to showcase their learning by sharing strategies with elementary principals. For this activity, participants volunteered to role play and model classroom strategies that can be used to respond to students' symptoms in the classroom. Furthermore, the participants explained to principals how they believe these strategies can be used in their individual classrooms. This showcase took place via Zoom.

Data Collection

Quantitative and qualitative data collection occurred before, during, and after the intervention program implementation. Specifically, data collection began in January 2020 after teachers consented to participate in the study. Before the intervention implementation teachers completed the MHLS and TEIP pretests. During the intervention, teachers engaged in the PD activities, as well as completed session exit-tickets, indicating their learning of session content. Finally, posttest surveys and a semi-structured focus group interview were conducted following the completion of the intervention program. Table 10 provides a timeline of data collection.

Table 10

Data Collection Timeline

Pre-Intervention January 2020	During Intervention January-June 2020	Post-Intervention June 2020
Mental Health Literacy Scale Pretest	Session exit-tickets	Mental Health Literacy Scale Posttest
Teacher Efficacy for Inclusive Practices Pretest		Teacher Efficacy for Inclusive Practices Posttest
		Semi-Structured Focus Group Interview

Quantitative Data Collection

Prior to starting the PD intervention, teachers completed the Elementary Teacher Mental Health Survey, which consisted of the MLHS and TEIP scales, as a pretest to determine their baseline knowledge and self-efficacy in recognizing and responding to student mental health needs. The questionnaire was administered and stored using a password protected Qualtrics account provided by Johns Hopkins University. Additionally, participants completed the same questionnaire following the completion of the PD program in June 2020. Participants received both the pre and posttest Qualtrics survey links at their school issued email addresses.

Qualitative Data Collection

During each PD session, participants completed exit tickets to share reflections about their experiences and learning through the information presented. During the January and February face-to-face sessions, teachers answered questions on paper copies of the exit tickets. To track exit ticket responses, teachers created an easily remembered four-digit code and included this unique code on the exit-tickets. Once the PD sessions transitioned to an online platform, teachers completed web-based session exit-tickets.

Furthermore, upon completion of professional learning sessions, the researcher requested teacher participation in a semi-structured focus group interview. The focus group interview allowed for data collection about the extent to which teachers' knowledge of mental health disorders, as well as self-efficacy in working with students with mental health disorders increased through the intervention. As such, parallel questions were used. Creswell and Plano Clark (2018) note that asking parallel questions about the same concepts allows the two datasets to be readily compared and merged.

Data Analysis

The study relied on a convergent parallel mixed method design, which involved the concurrent collection of quantitative and qualitative data. Creswell and Plano Clark (2018) suggest that a combination of a quantitative and qualitative data offers a more comprehensive description of the data collected. With that in mind, after quantitative and qualitative data collection, the researcher analyzed the pre and posttests using descriptive statistics. Furthermore, emergent coding was used for qualitative data to discover themes. Integrating both datasets allowed the researcher to determine how the results "confirm, disconfirm, or expand each other" (Creswell & Plano Clark, 2018).

Quantitative Analysis

The researcher utilized SPSS software to analyze quantitative data collected through the study. The researcher used descriptive statistics to analyze quantitative process evaluation data, such as attendance logs. Utilizing descriptive statistics allowed the researcher to summarize data.

Likewise, the researcher used SPSS to obtain descriptive statistics to summarize the MHLS and TEIP pre and posttests to gain a deeper understanding of measures of frequency and central tendencies. Descriptive statistics revealed emerging patterns in the data sets (Lochmiller & Lester, 2017). Furthermore, the pre and posttest MHLS and TEIP survey responses were compared using a dependent t-test. Dependent t-tests compared means between two related groups (Lochmiller & Ester, 2017). The dependent t-tests determined if a statistical difference exists between the pretest and posttest results for teacher knowledge and teacher self-efficacy.

Qualitative Analysis

For analysis of the focus group data, the researcher utilized a first and second cycle coding process. The first cycle coding process involved reading through the dataset and

identifying statements of substantive interest (Miles et al., 2013). An emergent approach (Glaser & Strauss, 1967) guided the analysis of the qualitative focus group data to allow for codes and themes related to teachers' knowledge and self-efficacy to develop. Specifically, the researcher utilized emergent descriptive and in vivo coding. Miles et al., (2013) note that these elemental approaches serve as "foundation approaches to coding" (p. 74).

Following first cycle coding, the researcher utilized Nvivo software to analyze the dataset to look for patterns and create categories. Pattern coding provides a way to group data summaries into smaller categories to allow emergent themes to be identified (Miles et al., 2013). This process took place until saturation of patterns provided a clear understanding of the data (Lochmiller & Lester, 2017). Lochmiller and Lester (2017) note that saturation can be defined in the analysis when "no new information and understanding is generated" (p. 178).

While analyzing qualitative data, the researcher considered bias that might influence meaning-making. As a teacher in the district, the researcher recognized that bias may influence findings. Finding evidence from focus group datasets, supported codes, and thematic analysis helps avoid biases stemming from the researcher's personal experiences (Lochmiller & Lester, 2017). Additionally, while reading through transcripts, the researcher took notes in a journal to keep track of personal thoughts and feelings.

Conclusion

This chapter presented a theory of change and a logic model for the proposed intervention. Specifically, the proposed intervention included a PD program aimed at increasing teacher knowledge of mental health disorders, as well as increased self-efficacy in responding to students by utilizing classroom strategies with students exhibiting mental health needs. The chapter also

presented the strengths and limitations associated with the PD intervention. Table 11 shows a data matrix, which summarizes how the measurements align to the research questions.

Table 11

Data Matrix Summary

Research Questions	Data Collection	Data Analysis
Process Evaluation		
RQ 1: What proportion of the target population participated in each PD session?	Quantitative: Attendance log	Descriptive Statistics
RQ 2: To what extent were learning objectives met for each session?	Qualitative: Session exit-tickets	Organized, coded for themes
Outcome Evaluation		
RQ 3: To what extent did the participation in the PD sessions increase teacher knowledge of childhood mental disorders symptoms and signs of student distress?	Quantitative: Pre and post survey	Descriptive statistics, t-test,
	Qualitative: Semi-structured focus group	Organized, coded for themes
RQ 4: To what extent did participation in the PD sessions influence teachers' self-efficacy in recognizing and responding to student mental health symptoms and distress?	Quantitative: Pre and post survey	Descriptive statistics, t-test,
	Qualitative: Semi-structured focus group	Organized, coded for themes

Using quantitative and qualitative data collection offered multiple sources for analysis and evaluation of the process and intended outcomes of the PD program intervention. The data collected through this mixed methods study was used to determine whether the short-term outcomes of teacher mental health knowledge and teacher self-efficacy in recognizing and responding to student mental health needs were met through the intervention program. The study

provided a greater understanding of teachers' perceived ability to recognize symptoms of mental health disorders and self-efficacy in recognizing and responding to student mental health needs.

CHAPTER FIVE

Results and Findings

Approximately four million children in the United States have a diagnosable mental health disorder (Bardach et al., 2014). A growing number of children require inpatient psychiatric hospitalization for acute mental health symptoms, including depression and suicide ideation (Chun et al., 2016). Current research suggests that ten percent of all pediatric hospitalizations are attributed to primary mental health diagnoses (Bardach et al., 2014). Children often return to school shortly after discharge, necessitating school staff become prepared to respond to students' mental health symptoms in school and classroom settings (Blizzard et al., 2016). Chapter one presented current research indicating that elementary teachers often feel unprepared to recognize and respond to students with mental health needs (Alisic, 2011; Reinke et al., 2011; Savina et al., 2014).

Similarly, the needs assessment results explained in chapter two indicate that teachers need training in disorder symptomology, classroom strategies to help students in distress, and referring students for school services. Participants self-reported that they have limited knowledge and self-efficacy when working with students with mental health disorders. Additionally, participants suggested that they wanted more PD to help them understand mental health disorders and effective strategies to assist students who exhibit emotional distress. As such, this study investigated the impact of a PD program on elementary teachers' mental health knowledge and self-efficacy in working with students with mental health disorders.

The student mental health intervention described in chapter four provided approximately 18 hours of PD focused on mental health disorder content and classroom behavior strategies to respond to mental health symptoms. Only sessions one and two also included embedded practice

due to school closures for the remainder of the intervention. With that in mind, the current study examined the effectiveness of a mental health PD intervention for elementary teachers.

Implementation Process

The PD intervention took place between January 9, 2020 and June 11, 2020. Study participants attended six monthly PD sessions that incorporated activities to increase mental health disorder knowledge, as well as increase self-efficacy in using strategies to respond to disorder symptoms and behaviors in the classroom setting. While the original PD plan indicated that all six sessions would be conducted in-person at one elementary school in the district, due to school closures, only the first two sessions were able to be done in-person. Therefore, teachers participated in sessions three through six via Zoom. Across both in-person and online formats, the sessions included approximately 18 hours of PD instruction and practice. Classroom practice stopped after session two, due to school closures. Practice in the classroom environment was included in the original PD plan, as literature shows that in context practice improves self-efficacy and change in practice (e.g., Borko, 2004; Tschannen-Moran & McMaster, 2009).

Prior to the start of the PD intervention, study participants completed an online pretest, consisting of questions related to demographics, mental health self-efficacy, and mental health knowledge. Elements of effective PD, including content-based and active learning (Jensen et al., 2016; Learning Forward 2011), guided the six sessions. With that in mind, session one included an introduction to the study and establishing collaborative norms, as well as activities to introduce one mental health disorder. The subsequent sessions included a variety of activities, modeling, and practicing identification and strategy practice. Lastly, session six included a showcase where study participants discussed their new learning and described classroom

strategies to elementary administrators. Following the PD intervention, study participants completed an online posttest and were invited to participate in a semi-structured focus group.

The intervention activities aimed to align with the proximal outcome of increasing participants' knowledge of mental health disorders and self-efficacy in utilizing classroom strategies to respond to students' externalized and internalized behaviors. The PD plan (Appendix C) outlines the activities related to the anticipated outcomes. The following sections of this chapter describe the study's implementation process and proximal outcomes.

Study Context

To develop a greater consideration of the study's findings, this section provides background information about the context of the intervention. Descriptive statistics provided information about participants' demographics and pre-intervention mental health knowledge and self-efficacy. The pretest survey revealed diversity within the study sample. As mentioned before, the intervention started with 10 participants, with one dropping out of the study due to the COVID pandemic. Therefore, the intervention participants for the study included 9 elementary teachers from four schools across the district, including two Title I schools. Additionally, the participants represented both female and male elementary teachers, as well as those in general education, special education, and language immersion positions. Specific demographic information of the nine participants who completed the intervention is described below.

Teachers in the sample included novice teachers, as well as those with up to 25 years of classroom experience. Participants included seven (70%) female, and two (20%) male elementary teachers. These gender demographics are unsurprising as the majority of elementary teachers in the district are female. Diversity of years of teaching experience existed among the participants. To be exact, two (20%) teachers had 0-4 years of experience, while one (10%) had

5-9 years, two (20%) had 10-14 years, three (30%) had 15-19 years, and one (10%) had 20-24 years. All of the participants with 0-4 years and 5-9 years of teaching experience held bachelor's degrees as the highest level of educational attainment. Similarly, one teacher with 15-19 years of experience also held a bachelor's degree as the highest educational attainment. Otherwise, all of the participants with 10-14 years' experience, two participants with 15-19 years' experience, and the participant with 20-24 years' experience all obtained master's degrees. No participant attained a higher education attainment level than a master's degree.

When further considering demographic information about grade levels and subjects taught, two (20%) of participants taught kindergarten through grade two, four (40%) taught grades three through grade five, two (20%) taught special education, and one (10%) taught in the district's Spanish immersion program. The special education teachers represented both the highest and lowest number of years of teaching experience and level of educational attainment. Specifically, while one special education teacher had 0-4 years of experience and held a bachelor's degree, the other had 20-24 years of experience and a master's degree. Table 12 shows participants' demographic information.

Table 12

Intervention Study Participant Demographic Information

Demographic Information	*n*
Gender	
Male	2
Female	7
Teaching Status	
Fulltime	7
Halftime	2

Demographic Information	*n*
Years of Teaching Experience	
0-4	2
5-9	1
10-14	2
15-19	3
20-24	1
25 or more	0
Highest Education Attainment	
Bachelor Degree	4
Master's Degree	5
Ed.S	0
PhD or EdD	0
Grades and Subjects Taught	
K-2 General Education	2
3-5.General Education	4
Spanish Immersion	1
Special Education	2
Intervention	0

Pre-Intervention Mental Health Knowledge

The pretest survey consisted of the MHLS (O'Connor & Casey, 2015), which measured teacher knowledge of mental health disorders and information location knowledge. Ten participants completed the pretest before the beginning of the intervention. The pretest survey results showed many participants had limited knowledge in mental health disorder risks and symptoms. On this subscale, the scores ranged from 24.00 to 37.00, with a possible score of 48. Table 13 shows the average composite mean score of the MHLS symptoms identification subscale before intervention.

Table 13

Average Composite Pretest Scores for the Mental Health Literacy Scale Symptom Recognition Subscale

	Minimum	Maximum	*M*	*SD*
Participants (n=10*)*	24.00	37.00	29.40	4.99

Considering specific survey items, the pretest results illuminated that participants frequently reported that they did not understand symptoms related to depressive disorders. On a 6-point Likert scale, from strongly disagree to strongly agree, participants disagreed (40%) or somewhat disagreed (60%) that childhood depression can include symptoms of sadness or irritability.

Additionally, the pretest revealed that participants disagreed (20%), somewhat disagreed (60%), somewhat agreed (10%) or agreed (10%) that social phobias include being nervous or anxious in social situations in which individuals would be afraid of being evaluated by others. Comparing group differences among grades taught, all participants either disagreed or somewhat disagreed that social phobias include symptoms of anxiety in social settings, with the exception of one special education teacher. That teacher was the only participant who agreed on the pretest that these symptoms were consistent with the diagnosis. Along with this, according to the pretest, the participants somewhat disagreed (40%), somewhat agreed (10%), or agreed (50%) that children with anxiety or phobias should avoid all activities that make them nervous. One disorder that teachers could correctly identify pre-intervention was bipolar disorder. All of the participants either agreed (50%) or strongly agreed (50%) that symptoms of bipolar disorder include emotional highs and lows.

Along with knowledge about mental health disorders, the pretest illuminated the participants' knowledge regarding where and how to seek mental health information. On the pretest, only one

participant (10%), a special education teacher, agreed in knowing where to seek mental health information. Conversely, 90% either disagreed (20%), somewhat disagreed (20%) or somewhat agreed (50%) in knowing where to seek information. Only one participant strongly agreed in knowing how to locate scientifically accurate information using the internet. That participant was a special education teacher with 0-4 years of teaching experience. Along with that, 70% of participants disagreed (30%) or somewhat agreed (40%) in having enough knowledge to talk to parents about mental health.

Pre-Intervention Self-Efficacy

Study participants also completed the TEIP (Sharma et al., 2012) as part of the pretest. The TEIP measured teacher self-efficacy in working with students with mental health disorders in the classroom environment. Though the pretest scores ranged from 49.00 to 73.00, the scale had a possible maximum of 90. Again, all ten participants' data was included in the pretest. Similar to the needs assessment, the pretest showed that teachers do not feel efficacious in working with students with externalized behaviors, such as aggressive behaviors. Table 14 provides a summary of the mean composite score from the pretest.

Table 14

Average Composite Pretest Scores of the Teaching Efficacy for Inclusive Practices

	Minimum	Maximum	*M*	*SD*
Participants (n=10*)*	49.00	73.00	59.60	8.50

Of the TEIP pretest, the item with the lowest mean score asked about dealing with children with aggressive behavior (*M*=2.67*, SD*=1.73*).* Participants also had low mean scores on the item asking about their efficacy in calming students exhibiting harmful behaviors (*M*=3.22*, SD*=1.09). Similarly, when asked about intervening when a student exhibits emotional distress, teachers reported limited self-efficacy (*M*=3.44*, SD*=.726). While 100% of the participants

somewhat agreed (30%), agreed (50%), or strongly agreed (20%) that they could make their expectations clear about behavior, only one participant strongly agreed in feeling efficacious in being able to get children to follow the rules. Similarly, only one participant strongly agreed in feeling efficacious in addressing aggressive behaviors. Taken together, the pretest evidenced that teachers do not feel efficacious when responding to mental health symptoms.

Findings

The goals for the remainder of this chapter include presenting the key research findings, as well as the findings' implications for practice and future research in the area of professional development in the area of elementary student mental health. To compare data from the pretest and posttest meaningfully, data from the dropped participant was excluded from further analysis. Therefore, the findings reflect the data collected from the nine participants who completed the entire intervention.

As stated in chapter four, two process evaluation and two outcome evaluation questions guided the current intervention study. The following questions are the basis for analysis within chapter five.

- Process evaluation question one: What proportion of the target population participated in each PD session?
- Process evaluation question two: To what extent were the learning objectives met each PD session?
- Outcome evaluation question one: To what extent did the participation in the PD sessions influence teacher knowledge of childhood mental disorders symptoms and signs of student distress?

- Outcome evaluation question two: To what extent did participation in the PD sessions influence teachers' self-efficacy in recognizing and responding to childhood mental health disorders and signs of student distress?

Intervention Dose (Process Question One)

Process evaluation question one of the study was: What proportion of the target population participated in each PD session? The intervention included six monthly PD sessions, each session lasting 2.5 hours. The intervention took place from January 2020 through June 2020. Completeness of the PD sessions was essential for understanding mental health symptoms and utilizing behavioral strategies in classroom environments

Analyzing the study participants' experiences within the student mental health PD sessions necessitated an examination of implementation fidelity. Dusenbury and colleagues (2003) describe implementation fidelity as the extent to which the PD sessions were implemented as designed. The content information drew from the HLT curriculum and Be You online resource. Discrepancies in implementing the intervention could bring about inaccurate results surrounding the monthly PD sessions. With that in mind, the evaluation of the current PD intervention required the examination of dose. For this study, dose is defined as the amount of programming content received by the participants (Dusenbury et al., 2003).

Current PD literature indicates that effective PD includes opportunities to apply learning in natural contexts, as well as exchange reflections and work on refinement with fellow teachers (e.g., Swan-Dagen et al., 2014). Accordingly, the original PD design included time for the participants to engage in reflective dialogue about their classroom experiences. While the nine participants attended each 2.5-hour PD session, due to school closure related to the COVID-19 pandemic, they did not have the opportunity to practice identifying mental health symptoms and

utilizing behavior strategies in their classrooms during the entire duration of the PD course. Specifically, the participants practiced identification and classroom strategies during January and February before school closure.

PD session attendance logs provided quantitative data for analyzing participant dose. The intervention began with 10 elementary teachers. Because of mandatory school closures due to the COVID-19 pandemic, one teacher discontinued participation in the study after the second session, which took place in February. According to attendance logs, the remaining nine participants completed all monthly PD sessions, thereby receiving the full available dose of the intervention.

Program Adherence (Process Question Two)

Process evaluation question two asked: To what extent were the learning objectives met each PD session? In this study, the learning objectives being met each session defined program adherence. The learning objectives of each study session included (a) defining of mental health disorders, (b) recognizing symptoms of mental health disorders, and (c) understanding when and how to respond to student symptoms of mental health disorders.

To measure whether the study met all of the learning objectives established by the research plan, participants completed qualitative written responses, in the form of an exit ticket, at the end of each PD session. As described in chapter four, exit tickets included short written responses pertaining to learning objectives (process evaluation questions), as well as participants' knowledge and self-efficacy related to student mental health (outcome questions). During sessions one and two, participants completed these exit tickets in paper and pencil form. However, with shifting to an online PD format, from session three to the end of the intervention, exit tickets were collected through Google Forms. The learning objectives were established in

the PD plan and presented in the session outlines and explained by the researcher at the beginning of each session. Each session included mental health disorder symptom recognition and classroom strategy objectives. Table 15 displays the goals and activities for each PD session. The entire PD plan (Appendix C) includes the learning topics and objectives of each session, as well as the exit tickets questions.

Table 15

Professional Development Session Goals

	Session Goals
Session One	Introduce learning PD session format Establish norms and expectations for sessions Discuss the importance for teachers to understand mental health Identify depressive disorder symptoms and risk factors Model and practice classroom strategies Develop calm zones expectations and procedures Practice using emotion vocabulary in reading workshop
Session Two	Discuss depression in collaborative groups Define and identify symptoms of anxiety disorders Compare anxiety and depression in small groups Model and practice classroom strategies Introduce feelings lockbox Strategy for negative self-talk (inner-critic strategy) Play Silly Street and discuss how to use across grade levels
Session Three	Discuss classroom experiences with strategies and create adjustments Identify PTSD risk factors and symptoms Practice differentiating between disorders introduced thus far Model and practice classroom strategies Describe and practice grounding strategies and give feedback
Session Four	Identify conduct disorder risk factors and symptoms Participate in activities to compare and accurately identify depression, anxiety, PTSD, and conduct disorder symptoms Model and practice classroom strategies Practice deep breathing exercises with small group with feedback Practice nonviolent communication strategies Collaborate in adjusting strategies for various grade levels

	Session Goals
Session Five	Identify ADHD risk factors and symptoms Develop questions to ask parent panel Discuss and reflect on parent panel conversations Model and practice classroom strategies Create visual reminders for classroom use Develop and create brain break tools for classroom use
Session Six	Identify OCD risk factors and symptoms Participate in learning showcase with administrators Teach administrators about disorders Describe most helpful learning activities

Along with the exit ticket responses, at the conclusion of the PD intervention, all study participants were invited to join a semi-structured focus group, in part to provide feedback about the learning objectives. The analysis of these qualitative datasets provided insight into the extent to which learning objectives were met over the course of the intervention. Qualitative data provided the answer to this process evaluation question. For analysis of the exit ticket and focus group data, the researcher used a first and second cycle coding process. The focus group data yielded two emergent themes, professional development content and instructor quality, related to adherence.

Professional Development Content Theme

Related to the first research question, the first emergent theme of professional development content covered the course information and activities. Two codes, information quantity and engaging activities, comprised the theme. Specifically, responses from the semi-structured focus group interview at the conclusion of the intervention illuminated that participants felt that the quantity of information about symptom identification and behavior strategies, as well as engaging activities influenced the extent to which learning objectives were met in each session. Table 16 highlights the professional development content theme, codes,

brief descriptions of the theme and codes, as well as excerpts from participants' exit ticket and focus group interview responses.

Table 16

Teachers' Perception of Adherence for Professional Development Theme

Content Codes	Description	Evidence Examples
Information Quantity	The amount of information presented each session to meet the learning objectives each session.	"Taking sessions piece by piece helped us learn a lot, but not be overwhelmed by the information." (Participant Four) "I learned more than I expected because each session we built on what we learned before." (Participant Five)
Engaging Activities	The PD learning activities used to meet the learning objectives each session	"Creating the brain model was an interesting way to develop our understanding of the parts and how they play a role in mental health." (Participant Two)

Information Quantity. Each session included learning objectives related to symptom recognition and classroom behavioral strategies to respond to students' mental health symptoms. Qualitative analysis revealed that the amount of information presented influences PD experiences. Participant Five noted that, "PD is usually overwhelming because so much information is presented, but not a lot of time for processing. That makes it difficult to remember and apply the material." Similarly, Participant Three stated, "when it's so overwhelming I don't think the learning objectives can be met. I mean, we haven't really learned what they're trying to teach."

When asked about learning objectives specific to this study's content, five of the focus group participants commented that the quantity of mental health information delivered in the sessions seemed appropriate. They noted that the amount of information taught in each session was reasonable for them to be able to understand and apply the identification and behavioral strategies explained in each session. While the content was extensive, Participant One reflected on the amount of information in each session. She said,

> I feel like the sessions were more depthy than they were breadthy. As teachers talk about breadth and depth. The sessions went into a topic well, without just giving you a bunch of information that you couldn't understand or didn't want to know.

Along those same lines, another participant explained that in the sessions content "was covered piece by piece to give a deeper knowledge of the subject" (Participant Two). Furthermore, Participant Seven and Participant Three suggested that the amount of information and practice, while intense, was fitting because teachers do not need to diagnose or provide treatment for students, but rather help students in the moment. With that in mind, Participant Five commented that the sessions included in-depth information pertaining to mental health disorder identification and classroom strategies. She said,

> There's a lot of material, and once you're in the classroom you can make a decision in a matter of seconds. It can be frightening, and that's where the importance of that extensive training, where it becomes almost second nature, where right at the moment of the crisis, you don't have to think, is it this or is it that, or do I do this?

Considering the session exit ticket responses, Participant Seven noted that he felt the amount of information presented about childhood disorders was helpful in learning how to recognize

symptoms and distinguish them from other disorders, while also devoting time to modeling and practicing classroom strategies.

Not all participants felt the amount of information was appropriate for teachers. Participant Eight discussed in the focus group how the sessions included an extensive amount of information, making the content difficult to grasp. Similarly, she thought developing one behavior strategy really well, rather than learning many would be more beneficial in working with students in a classroom setting. For example, she commented that focusing on the most common disorder and the most effective behavior strategy would be more useful than devoting each session to a separate mental health disorder.

Engaging Activities. The code engaging activities refer to the types of instructional methods and learning activities used to meet the learning objectives. Effective teacher PD includes multiple instructional methods to teach content and increase self-efficacy. (e.g., Tschannen-Moran & McMaster, 2009). While participants completed exit tickets at the end of all six sessions, sessions one through three asked specifically about the extent to which participants learned what they had anticipated. All ten participants in sessions one and two, and all nine participants in session three revealed that the learning activities positively influenced how learning objectives were met. Illustratively, Participant Nine expressed on the session two exit ticket that learning about mental health disorders was challenging but "activities like creating the brain hat developed an understanding of the brain parts in an engaging way." Furthermore, four of the study participants also communicated that learning activities, such as role-playing and playing games, sustained their attention during the PD sessions, helping them learn important information about mental health and how to help students. For example, Participant One commented that doing gallery walks and playing games "gave me the chance to work with others

and try these things out in a fun and interesting way." Also, another teacher noted that the PD sessions presented information "in such a great way, and now we can take some of these things that we've learned and apply these" (Participant Two).

Along with exit ticket data, participants commented on the learning activities during the focus group interview. Similar to Participant Nine, Participant Three discussed the benefit of creating the brain hat model in understanding the underlying neurobiological influences in mental health disorders. She said,

> In the early sessions when we were talking about the brain and you had us do the model of all the different parts of the brain just to really develop that understanding of the parts and how they play a role in mental illness. I just thought that was so helpful and helped me understand mental health disorder risks and symptoms.

The qualitative data shows that the participants believed that the PD activities helped in understanding the mental health content.

Instructor Quality Theme

The second emergent theme related to program quality, instructor quality, focused on the researcher's ability to meet the learning objectives during each PD session. The code related to the instructor quality theme is instructor classroom experience. The researcher acted as the instructor during this PD course. The researcher had 19 years of teaching service with general and special education student populations. Learning Forward (2011) suggests that PD involving teacher leaders often positively affects teacher changes in practices. Table 17 highlights the instructor quality theme and instructor classroom experience code.

Table 17

Teachers' Perception of Program Adherence for Instructor Quality Theme

Instructor Quality	Description	Evidence Examples
Instructor Classroom Experience	The researcher's background knowledge and teaching experience influenced how the learning objectives for symptom identification and behavioral strategy use were met each session.	"I learned more than expected. You could tell us how this would play out in a classroom setting." (Participant One)

Instructor Classroom Experience. Study participants noted that the PD instructor's classroom experience provided a unique perspective of how mental health symptoms manifest in a classroom environment. Moreover, participants commented that an instructor with classroom experience was beneficial in teaching them practical ways to respond to symptoms in the classroom. Participant Nine noted that "you bring a depth of experience from being a teacher." In the focus group interview Participant Two offered,

> I respected and appreciated the classroom background that you've had. So, you're able to give us information and strategies that you know we need. You're able to give us information and strategies that you have tried and know they are classroom appropriate for teachers to use. I think you bring a depth of experience, obviously, from being a teacher and working with kids.

Along with this, in each of the six exit tickets, at least one participant noted that the instructor's teaching experience was advantageous to meeting the session learning objectives. In reference to the instructor's classroom experience, Participant One said that "you've already done it, you've tried it, you have knowledge of how to do it with children in a classroom of 25 to 30 children." Likewise, Participant Nine shared in her written response that teachers work in an

environment that includes many students and activities, including academics, thus, understanding the classroom environment and dynamics was helpful. Moreover, Participant Five wrote in her session one exit ticket that it was "refreshing to have someone who understands what we need help us work through this information." In session three, she went on to say that she felt the learning objectives were met because the instructor's background in education helped make the learning applicable and understandable.

Similarly, all of the focus group participants commented that the instructor's familiarity with classroom dynamics helped them learn to recognize mental health symptoms and use behavioral strategies. Focus group Participant Three noted that the instructor's classroom experiences facilitated meeting the learning objectives of each session. Specifically, she said,

> The district usually has psychologists or therapists do training for teachers. In those settings there is a different ratio. It's one to one, like one adult to each child. These are ratios that make us tune out. They make me think they're not in a classroom so how would they even know what it's like. So, they can't really meet the learning objectives. They can't help us learn what to do, because they don't know how to do it in a classroom. This PD met the learning objectives because it helped us to learn how to recognize symptoms and address behaviors because you know the logistics of a classroom.

The response Participant Three offered was typical of exit ticket and focus group responses that participants provided. Participants suggested that having an instructor with teaching experience influenced the extent to which learning objectives were met.

Teacher Mental Health Knowledge (Outcome Question One)

Outcome question one focused on whether participants' knowledge of mental health disorders increased through the student mental health PD course. Specifically, outcome evaluation

question one investigated: To what extent did the participation in the PD sessions influence teacher knowledge of childhood mental disorders symptoms and signs of student distress? The MHLS (O'Connor & Casey, 2015) provided a quantitative measure for understanding participants' knowledge of mental health disorders. To gain richer insight into mental health knowledge, the researcher also relied on qualitative data gathered through the session exit tickets and focus group interview. The exit tickets and focus group interview included questions specific to mental health knowledge.

Quantitative Findings for Teacher Knowledge of Childhood Mental Health Disorders

The PD course dedicated sessions to (a) childhood depression, (b) anxiety, (c) PTSD, (d) conduct disorder, (e) ADHD, and (f) OCD. Each session aimed to increase teacher knowledge of mental health disorder symptoms to meet the short-term outcome of increasing participants' recognition of mental health disorders. With that in mind, mental health knowledge pretest and posttest scores were measured using the MHLS (O'Connor & Casey, 2015). Table 18 shows the mean composite scores of the pretests and posttests.

Table 18

Pretest and Posttest Composite Scores on the Mental Health Literacy Scale Symptom Recognition Subscale

	n	Minimum	Maximum	*M*	*SD*
Pretest	9	24.00	37.00	29.11	5.20
Posttest	9	32.00	45.00	39.55	4.61

Across the pretests and posttests, the MHLS symptom recognition composite scores ranged from 24 to 45, with 48 being the highest possible score. In total, the mean score increased by 10.44. To investigate change in teachers' mental health knowledge through the intervention, the researcher conducted dependent t-tests to compare scores on the MHLS pre-intervention and

post-intervention. Based on the comparison of the composite pretest and posttest scores, the participants significantly increased their knowledge of mental health symptoms ($n=9$, $t=4.003$, $p<.001$).

Furthermore, all individual pretest and posttest scores regarding the ability to recognize mental health disorder symptoms and risk factors and causes were compared using dependent t-tests. Out of the 10 items about symptom recognition, one was significant at the .05 level and four were significant at the .01 level. The comparisons with the highest t-value was item three on the MHLS, which measures the ability to recognize symptoms related to major depressive disorder ($n=9$, $t=6.23$, $p<.000$). Additionally, results evidenced statistical significance of the participants' perceptions of their ability to identify symptoms of social phobias ($n=9$, $t=4.00$, $p<.004$). Results also show statistical significance in participants' perceptions of their ability to recognize symptoms of agoraphobia ($n=9$, $t=3.350$, $p<.010$), personality disorders ($n=9$, $t=3.092$, $p<.015$), and pervasive depressive disorder ($n=9$, $t=2.219$, $p<.05$). Along with this, all pretest and posttest scores regarding knowledge of professional help available and appropriate help-seeking subscales were compared using dependent t-tests in SPSS. Of these subscales, the item with the highest t-value was recognizing mental health disorders as real diagnoses ($n=9$, $t=5.657$, $p<.000$). While analysis showed statistical significance, due to the low sample size, caution should be taken when interpreting these results.

The pretest indicated that most of the nine participants did not believe that mental health disorders in children were real. Descriptive statistics showed that at the time of the pretest, 55.5% of participants somewhat agreed (33.3%), or agreed (22.2%) that children have the ability to snap out of mental health symptoms when they want. Likewise, 66.7% of participants somewhat agreed (11.1%) or agreed (55.6%) that students with mental health symptoms should

avoid all activities or situations that evoke internalized or externalized behaviors and symptoms, particularly considering anxiety.

Posttest data illuminated differences in participants' knowledge of these topics. Specifically, 100% of participants strongly agreed that mental health disorders are real diagnoses. Also, the results showed a decrease in the number of participants who felt that students can snap out of exhibiting behaviors. Specifically, after the intervention only two participants (22%) somewhat agreed, while no participants agreed or strongly agreed that children can snap out of their symptoms. Finally, only 22.2% of participants somewhat agreed (11.1%) or agreed (11.1%) that children should avoid all activities or situations that evoke mental health symptoms.

The survey includes questions related to symptoms of childhood mental health disorders that were explicitly taught in the PD sessions. The MHLS provides symptom descriptions related to anxiety disorders and depressive disorders. Differences in teacher knowledge about mental health disorders and symptom recognition exist between the pre and posttest results. As indicated earlier in the chapter, at the time of the pretest, only one participant (11.1%) was able to correctly identify symptoms related to social phobia. Similarly, two participants could correctly identify symptoms related to generalized anxiety disorder. However, all of the participants could accurately identify and describe bipolar disorder. The posttest indicated that most participants could accurately identify the covered disorders based on symptom descriptions. Table 19 highlights the descriptive statistical analysis of the MHLS (O'Connor & Casey, 2015).

Table 19

Summary of Means, Standard Deviations, Range of Scores on the Mental Health Literacy Scale

Mental Health Literacy Scale	*n*	*M*	*SD*	Minimum	Maximum
Pre Social Phobia	9	3.11	.928	2	5
Post Social Phobia	9	4.44	.882	3	5
Pre Generalized Anxiety Disorder	9	3.56	1.014	2	5
Post Generalized Anxiety Disorder	9	4.22	.972	2	5
Pre Major Depressive Disorder	9	2.56	.527	2	3
Post Major Depressive Disorder	9	5.11	.928	4	6
Pre Personality Disorder	9	3.67	1.581	2	6
Post Personality Disorder	9	5.22	.667	4	6
Pre Pervasive Depressive Disorder	9	4.00	1.500	2	6
Post Pervasive Depressive Disorder	9	5.33	.707	4	6
Pre Agoraphobia	9	3.56	1.333	2	5
Post Agoraphobia	9	5.44	.726	4	6
Pre Bipolar Disorder	9	5.56	.527	5	6
Post Bipolar Disorder	9	5.56	.527	5	6

The descriptive statistical analysis showed that the PD increased their knowledge of mental health symptoms and risk factors of all the disorders, except bipolar disorder, found on the survey. For example, when recognizing symptoms of major depressive disorder, the pretest shows a mean of 2.56, and a posttest mean of 5.11. As mentioned above, teachers experienced significant growth in accurately identifying symptoms related to major depressive disorder between the pretest (*n=9, M=2.56, SD=.527)* and the posttest (*n=9, M=5.11, SD=.928, p=.001*).

According to these results, participants disagreed that major depressive disorder includes symptoms such as sadness that goes beyond the typical feelings of unhappiness that a child might experience, as well as irritability and somatic symptoms. However, on the posttest, the mean score illuminates that participants agreed that major depressive disorder includes these symptoms.

Qualitative Findings for Teacher Knowledge of Childhood Mental Health Disorders

Along with the quantitative data from the pre and posttest knowledge information from MHLS (O'Connor & Casey, 2015), the PD session exit tickets and focus group provided qualitative data about the participants' knowledge of mental health disorders. The analysis of the qualitative data revealed the emergent theme, Mental Health Literacy, consisting of two codes, Mental Health Identification and Misconception Clarification.

Mental health literacy can be described as having an understanding of mental health symptoms and treatments, decreasing mental health stigma, and developing help-seeking skills (Weston et al., 2008). Table 20 features the theme and codes, a brief description of the theme and codes, and excerpts from participants responses on the exit tickets and focus group.

Table 20

Mental Health Literacy Theme Response Codes

Code	Description	Evidence Examples
Mental Health Identification	Awareness of mental health disorders and mental health disorder symptoms.	"I think I've become aware a lot of abundance more of types of mental illnesses and things that I didn't realize that children even could have." (Participant Three)
Misconception Clarification	Resolve to previously held misconceptions about childhood mental health disorders and mental health symptoms	"I thought that children with depression would look just like adults with depression. You know, just sad." (Participant Nine)

Mental Health Identification. Each exit ticket included questions pertaining to mental health knowledge and identification, aligning to outcome question one. These questions asked about the participants' ability to recognize mental health symptoms or new learning about mental health disorders. Many of the responses suggested that the participants' recognition of mental health disorders changed over the course of the PD sessions. Specifically, participants noted that the PD sessions helped them become aware of diagnosable childhood mental health disorders. For example, Participant One noted in session six that,

> I feel comfortable knowing that I'm not diagnosing these things. You've said that over and over that I'm the teacher, not making a diagnosis. That's not a teacher's job. It's good because I didn't know the types of disorders children could have before this course. Now I know that children can have depression and anxiety. These are real things that kids can be diagnosed with.

Along similar lines, Participant Two also commented in session six that the PD sessions "created greater awareness of mental health issues that kids can have and that they are real. For example, I didn't think of anxiety as a disorder, just a feeling." These written responses align with the quantitative survey findings. The descriptive statistics and exit ticket responses show that participants increased their awareness of mental health disorders by expressing that mental health disorders are childhood medical diagnoses.

In addition to developing an awareness of the childhood mental health disorders, the written exit ticket responses showed that participants' knowledge in symptom identification increased through the PD course. To exemplify, in session one, Participant Nine noted that "I don't think I could identify a child with depression yet. I think all disorder symptoms look similar." By session six, the same participant noted, "I really have a better understanding of what mental health is and looks like for students. I can pick up more on subtleties." Likewise, Participant Seven commented in session five that,

> the more I learn from these sessions, the more I realize that many disorders are distinct, but also may have similar symptoms. I know that depression and anxiety may show signs of irritability, not just sadness. But, being quiet and withdrawn could be symptoms, too. Recognizing symptoms is important to helping the child with appropriate strategies.

In addition to the exit tickets, the focus group participants discussed their ability to recognize various mental health disorders. Similar to the exit ticket responses, most participants explained that they are now able to identify mental health disorders. Participant Four explained that he developed an awareness of how mental health symptoms look in his students. Specifically, he said,

> I thought for the population of students in Spanish Immersion that we didn't have these issues in our classrooms. But, now I see signs of symptoms in students that I wouldn't have before. I think I would have brushed it off, not thinking these issues are here.

Although most participants noted that they increased their knowledge of mental health disorders, Participant Eight described feeling overwhelmed by the information related to symptoms recognition. The teacher noted that the more information presented, the more confused she became. Specifically, she said, "the more I know, the more I feel like symptoms could be this, or it could be this, or it could be this."

Misconceptions Clarification. Along with learning new information to recognize and identify mental health symptoms, the qualitative datasets illuminated the ways that the PD intervention unearthed, examined, and clarified participants' misconceptions. Written exit ticket responses illuminated participants held misconceptions regarding symptom presentations in the classroom environment. Three participants wrote that they believed that symptoms associated with ADHD only included distractibility and impulsivity. The sessions clarified that students with ADHD could also exhibit self-focused behaviors and emotional dysregulation. Participant Nine wrote, "I believed that emotional turmoil was only related to disorders like depression or a conduct disorder. This is a new idea for me."

According to the survey pre and posttest, participants showed changes in their knowledge in a child's ability to manage mental health disorder symptoms. Specifically, participants reported changes about a child's ability to snap out of mental health symptoms throughout the session. Qualitative data also showed changes in teacher knowledge about symptoms and behaviors. Participants discussed their misconceptions related to classroom behaviors during the focus group interview. For instance, Participant Four stated that "you lose your patience, you

know, with kids and these behaviors. But, now I know there's more behind it." Participant Two agreed, saying,

> This has opened my eyes to the importance of having mental health knowledge. I feel as a result of this I am much more empathetic. Before I would have just told kids to cut it out. I would have just said that this kid is trying to get my attention. I would overlook this as bad behavior. I thought mental health was just a nice way of saying naughty. Now I know there is much more behind behaviors and symptoms.

Continuing the conversation, Participant One replied,

> after all of these sessions, knowing that there's some underlining problem or issue or disconnect or an inability, that's not necessarily, they're not trying to do it, or it's not something that they can control. I used to think they could control it if they wanted. So, then I know it is important for a teacher to support them in what they need. Having more knowledge of mental health helps us respond better.

Finally, the participants also commented in the qualitative datasets that they held misconceptions about how children develop mental health disorders. The teachers discussed that mental health disorders develop as a result of parenting issues, such as inconsistent parenting or abuse. As such, they believed that children develop mental health disorders primarily as a result of environmental factors. In the session six exit ticket, Participant Nine wrote, "I used to stigmatize families that they created mental health problems. Now I know that genetics and neurobiology play a role." Participant Five echoed similar thoughts during the focus group. Specifically, she explained, "I gained an understanding that the brain and brain chemicals play a role in mental illness." In response, Participant Five said,

> I can imagine now that even medicine side effects could play a role in symptoms. You know how commercials say that meds can make a person feel suicidal or have racing thoughts. I bet that can make a child show different symptoms and behaviors.

Participant Three added,

> I think also about the chemical makeup of your brain and the pieces and the parts of it and how they all work together. They can change based on developments that you've experienced, through trauma or not trauma. But, trauma isn't always the family doing something wrong.

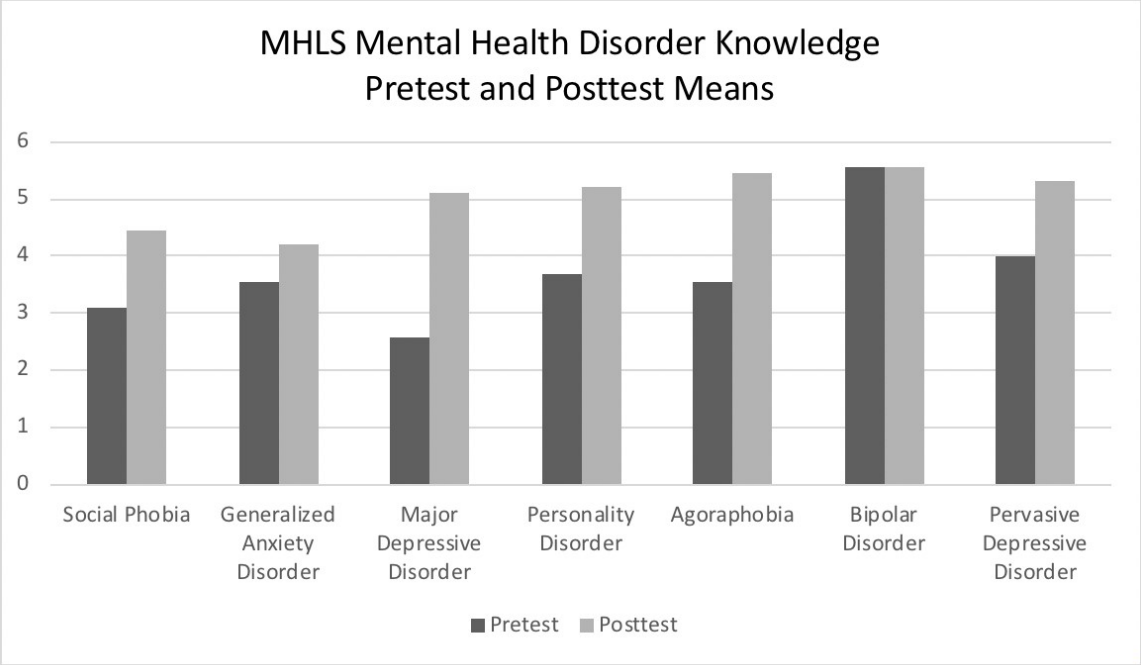
The written responses related to session three about trauma also indicated changes in participants' misconceptions about the etiology of mental health disorders. Participant Five included in her written response that she was not aware that natural disasters, medical treatments, and poverty can be associated with trauma. She noted that when she thinks of trauma "physical and sexual abuse come to mind." Similarly, Participant One noted that "now I know that things like COVID need to be thought about. What can we do to support kids as they come back to school?" Such responses reflected a new understanding that many factors play a role in children developing mental health disorders.

Mixed Methods Findings for Teacher Knowledge of Mental Health Disorders

Overall, the quantitative and qualitative results show that the study participants increased their mental health knowledge and their ability to recognize symptoms of mental illness. The comparison of the means between the preintervention and postintervention showed a statistically significant increase in their perception of their ability to recognizing symptoms related to health disorders. Figure 5 shows the means of the pretest and posttest findings.

Figure 5

Mental Health Literacy Scale Pretest and Posttest Means Comparison



Additionally, the qualitative exit tickets align with these findings, as participants learned that distress or aggressive behaviors can be symptoms associated with mental health disorders. Specifically, on an exit ticket, Participant One noted a change in understanding stating that, prior to the intervention, she believed that externalized or internalized behaviors may be intentional. After the intervention, the participant recognized that such behaviors may be the result of an underlying mental health issue or disorder. Likewise, Participant Four indicated that the PD revealed that externalized behaviors are not intentional misbehaviors or attention seeking behaviors but symptoms related to a disorder. Taken together, the quantitative and qualitative results revealed that PD sessions that include explicit instruction and activities related to a variety of childhood mental health disorders common to elementary students increases teachers' mental health knowledge

Teacher Self-Efficacy (Outcome Question Two)

The study's final research question focused on the extent to which the PD sessions influenced self-efficacy in working with students with mental health disorders in classroom settings. Specifically, outcome question two asks: To what extent did participation in the PD sessions influence teachers' self-efficacy in recognizing and responding to childhood mental health disorders and signs of student distress? The information in this section presents the key findings about teacher self-efficacy from the quantitative and qualitative participant data. The researcher collected and analyzed quantitative data using the TEIP (Sharma et al., 2012) scale for self-efficacy. Additionally, the session exit tickets and focus group interview provided qualitative data about the participants' PD experiences, as well as changes in self-efficacy. From the qualitative data, two themes emerged. The Applicability theme included Classroom Practicality and Strategy Modeling and Practice codes. Additionally, a second code, Continued Support, included Classroom Practice and District Policies codes. The quantitative and qualitative results are discussed in this section.

Quantitative Findings for Teacher Self-Efficacy

Self-efficacy pretest and posttest scores were measured using the TEIP (Sharma et al., 2012), which included 15 items pertaining to teaching students with special needs, including mental health disorders. The maximum score for the TEIP was 90. Table 21 provides a mean composite score for the pretest and posttest TEIP results.

Table 21

Pretest and Posttest Composite Scores on the Teaching Efficacy for Inclusive Practices Scale

	N	Minimum	Maximum	*M*	*SD*
Pretest	9	49.00	73.00	58.77	8.58
Posttest	9	64.00	78.00	70.67	4.00

To investigate change in teachers' self-efficacy through the intervention, a dependent t-test was used to compare changes of the composite TEIP scores. Teachers in the intervention showed significant growth in their average TEIP self-efficacy scores between the pretest (*n=9, M=58.77, SD=8.65*) and posttest (*n=9, M=70.67, SD=4.00, p=.001*). TEIP scores for self-efficacy in addressing harmful behaviors showed statistical significance between the pretest (*n=9, M=3.22, SD=1.093)* and posttest (*n=9, M=4.56, SD=.527, p=.004)* administration. Similarly, TEIP scores for self-efficacy in recognizing emotional distress showed statistical significance between the pretest (*n=9, M=3.78, SD=1.09)* and posttest (*n=9, M=4.89, SD=.667, p=.003)* administration. Because of the small sample size, caution should be taken when interpreting these results.

Descriptive statistics were used to analyze the TEIP (Sharma et al., 2012) pre and posttest results to gain a deeper insight into the participants' self-efficacy for working with students with mental health disorders. In a needs assessment in the district teachers reported on the TEIP (Sharma et al., 2012) having limited self-efficacy in calming students exhibiting harmful behaviors, as well as students who are physically aggressive. Before the PD course, teachers also reported limited self-efficacy in these areas. Specifically, 44.4% of the study participants self-reported that they somewhat agree (33.3%) or agree (11.17%) with being able to calm a child exhibiting harmful behaviors. No participant reported strongly agreeing to feeling confident in calming a child with harmful behaviors. Similarly, only 22.2% of participants reported on the pretest that they agree (11.1%), or strongly agree (11.1%) in feeling confident in responding to students' aggressive behaviors. However, after the PD sessions, 100% of participants either somewhat agree (44.4%) or agree (55.6%) that they are confident in addressing harmful behaviors in the classroom setting. Teachers' self-efficacy in responding to aggressive behavior

also increased, as reported on the posttest. Specifically, 100% of teachers somewhat agreed (77.8%) or agreed (22.2%) that they felt confident in responding to aggressive behaviors.

Regarding student behavior, the pretest indicated that only 44.4% of teachers somewhat agreed (22.2%) or agreed (22.2%) that they felt confident in their ability to prevent disruptive behavior in the classroom before it occurs. According to the posttest, 100% of participants somewhat agreed (22.2%), agreed (66.7%), or strongly agreed (11.1%) that they felt confident in preventing disruptive behaviors in the classroom. Along with this, 100% of teachers reported feeling at least somewhat confident in responding to students in emotional distress. Table 22 highlights the descriptive statistics for self-efficacy in responding to student behaviors.

Table 22

Descriptive Statistics for Behavior Recognition and Support

Teaching Efficacy for Inclusive Practices	*n*	M	S.D.	Minimum	Maximum
Pre Prevent Disruptive Behaviors	9	3.33	1.25	2	5
Post Prevent Disruptive Behaviors	9	4.89	.600	4	5
Pre Identify Distress	9	3.78	1.09	3	6
Post Identify Distress	9	5.22	.667	4	6
Pre Intervene in Distress	9	3.44	.726	3	5
Post Intervene in Distress	9	4.44	.527	4	5
Pre Harmful Behaviors	9	3.22	1.093	2	5
Post Harmful Behaviors	9	4.56	.527	4	5

Teaching Efficacy for Inclusive Practices	*n*	M	S.D.	Minimum	Maximum
Pre Follow Rules	9	4.67	.866	3	6
Post Follow Rules	9	4.89	.333	4	6
Pre Aggressive Behaviors	9	2.67	1.73	1	6
Post Aggressive Behaviors	9	4.22	.440	4	5
Pre Clear Expectations	9	4.89	.782	4	6
Post Clear Expectations	9	4.89	.333	4	5

Qualitative Findings for Teacher Self-Efficacy

Along with the quantitative data from the pre and posttest knowledge information from TEIP (Sharma et al., 2012), the PD session exit tickets and focus group provided qualitative data about the participants' self-efficacy for working with students with mental health needs. This section provides data about the themes and codes found through qualitative analysis. The analysis of the qualitative data revealed two emergent themes. First, the theme Applicability, referred to relevance of the information and strategies presented to the teachers in the PD sessions. The Applicability theme consisted of two codes, Classroom Practicality and Strategy Modeling and Practice, which emerged using the NVivo program. Second, the theme of Continued Support emerged, which consists of two codes, including Classroom Practice and District Policies. The Continued Support theme was described as the help that the teachers' needed to feel confident in teaching children with mental health disorders following the PD intervention. Table 23 features

the themes and codes, a brief description of the themes and codes, and excerpts from participants responses on the exit tickets and focus group.

Table 23

Themes and Codes for Teacher Self-Efficacy

Theme	Code	Description	Evidence Examples
Applicability	Classroom Practicality	Teacher-friendly strategies for symptom identification and behavioral strategy use	"The learning was fruitful because it was user-friendly for us in a classroom of multiple children at a time." (Participant Three).
Applicability	Strategy Modeling and Practice	Symptom recognition and behavior strategy active learning	"I have more tools in my tool box than I have ever had before now that I have seen them being used." (Participant Seven)
Continued Support	Classroom Practice	Practice in the classroom setting with students	"Seeing how it plays out in a classroom setting will also help boost my confidence in putting into practice what you've taught us" (Participant Two)
Continued Support	District Policies	Policies at the district level that promote common mental health understandings	"I think we'd all feel more confident in working with students if we felt like we knew what we were dealing with, whether it's trauma or something else. Identifying disorders built my confidence in responding" (Participant Nine)

Classroom Practicality. In the theme Applicability, or the relevance of the information and strategies taught through the PD sessions, practical classroom strategies were the most common topic that surfaced. All focus group participants noted that receiving practical classroom strategies increased their self-efficacy in working with students with mental health disorders because the strategies were teacher-friendly. Likewise, all ten participants in session 2 commented that the practical strategies presented and practiced made them feel more confident in responding to students' needs. Participants gave similar feedback in their written responses in sessions three, four, five, and six. For example, one participant shared that "it was definitely user friendly for us in a classroom of multiple children at a time" (Participant One).

Before mandatory school closures, teachers had the chance to use the PD strategies for two months. With that in mind, on exit ticket two, Participant Nine wrote,

> I tried these strategies from session one with my class. They were easy to implement, even with a class of 24 kids. I didn't have any children with big behaviors, but they even worked to put out small fires."

Moreover, Participant Eight included on exit ticket two that using realistic strategies in class increased her confidence in responding to students' needs. Specifically, she wrote,

> So, you've really helped to clarify some things and just giving us those strategies. I felt confident using them. They're helpful even when things arise in our classrooms or in our day to day. In our day to day, I feel like many of these things, we can just use in our interactions.

Although he did not have the opportunity to use the strategies in the classroom, on exit ticket five, Participant Four wrote,

> I think that the strategies that were shared today could really be adaptive to all children in a class. The strategies will take some teaching and explaining but I feel confident that it is doable and will really help many students. I am grateful that the strategies are not "hard" or time consuming. It would not be a daunting task to teach these when needed or when starting up a classroom.

Similarly, during the focus group conversation, Participant Two shared,

> I love that you offered your knowledge and expertise during each session, but then also gave us some real practical things that we could do as teachers. I felt like, wow, I can use this. This is going to help me moving forward, because I've gained this new knowledge. I feel like in every session, there are small changes that I can make personally that may impact kids in big ways going forward. They were realistic strategies.

The written and oral responses conveyed that the practical classroom strategies improved their confidence in working directly with students.

While many participants expressed that the practical strategies shared and practiced in the PD sessions influenced their self-efficacy in working with students, focus group participants also shared that their self-efficacy in help-seeking increased, too. Two participants communicated that knowing that user-friendly strategies exist for helping students, they feel more confident in searching for help with other resources such as school mental health providers or online resources. To illustrate, Participant Nine said that having more self-efficacy in recognizing and responding to students' needs, knowing that this can be done effectively in the classroom, she is "also more confident in asking for help in getting classroom ideas."

Strategy Modeling and Practice. Along similar lines, study participants illuminated that modeling and practice influenced the applicability of the information in each session and,

therefore, the extent to which they felt confident in recognizing and responding to student mental health symptoms. Each PD session included time to practice symptom recognition and classroom behavior strategies. The researcher modeled strategies, which the participants practiced in small groups and received feedback from colleagues. Participant One pointed out that watching strategies being modeled increased her confidence in applying strategies in the classroom because she knew what to expect. Participant Two added that having the strategies modeled increased her confidence because she could envision the "logistics in how it worked in a classroom with kids."

Participants also revealed that practicing the strategies influenced their self-efficacy. Participants One, Two, and Three suggested that practicing the strategies prepared them for what would happen in the classroom. Participant Two also commented that,

> I appreciate the teacher aspect of it. Not just tell us here go and do this. But explain it and try it out. Let us practice and see how it feels. Acknowledge that it feels different talking about it than actually doing it. You helped us learn how to do it in a classroom of 25 or 30 students.

Classroom Practice. The theme Continued Support includes the code classroom practice. As aforementioned, the focus group revealed that additional opportunities for role-playing and feedback would have been helpful in developing self-efficacy. With that in mind**,** current literature suggests that teachers who engage in intensive PD workshops should also receive ongoing support throughout the school year to deepen their content learning and understanding (e.g., Borko, 2004). Crosby et al., (2015) suggests that teachers who receive PD about student mental health should have support throughout the year for any questions or issues that arise.

The original PD design included strategy practice in the participants' classroom setting. However, classroom strategy practice became impossible after the second PD session when schools were shut down due to the pandemic. As such, while participants had the opportunity to practice recognition and behavior strategies, they did not have opportunities to try them in the natural context of the school classroom. When asked to describe what they still needed to feel confident in working with students with mental health needs, participants expressed the need to have support when school resumes in a face to face format. For example, Participant Two suggested that "seeing how it plays out in a classroom setting will also help boost my confidence in putting into practice what you've taught us." Likewise, Participant Four added that the PD sessions "paved the way for setting up routines and implementing effective tools, but it would be helpful to experience it with kids."

In addition to classroom practice, participants noted that continued PD would further their learning. Participant One spoke of her desire to continue learning with additional PD throughout the next school year. She indicated that "we have learned a lot, but I feel like we only just tapped the tip of the iceberg. There's so much that we should really be trained in to really be as effective as we can." Regarding additional learning, Participant Two requested having materials created, such as a poster, to have available in the classroom to reference, as well as continuing to have check-ins available for participants to ask questions, review, and collaborate.

District Policies. Regarding continued learning and support, the participants suggested that, along with additional PD opportunities, school district support is necessary to continue learning about children's mental health and developing self-efficacy towards supporting students who experience mental health challenges. All of the focus group participants conversed about needs at the district level. Of these needs, participants commented on the relationship between

common mental health knowledge and self-efficacy. Participant Two shared that she would feel more confident in working with students if the district established common mental health language. She said, “there's not a common knowledge or language of information. We’re all doing and saying different things.” Specifically, Participant Two noted, “take anxiety. Often, we use that just to say a kid is nervous. If we all talked about it in a way that showed it is an actual mental health diagnosis, I think we’d be more likely to understand each other and kids’ needs.” In response, Participant One added,

> We have spent a lot of good time on trauma for our district, but none of the other things that we talked about in this study were mentioned. It was just specifically childhood trauma, which was very helpful, but we also have to realize there's a whole obviously vast spectrum of other issues that children have, and we haven't addressed many in the district yet. So, we all have different ideas about what children are exhibiting. Every child who presents with some sort of behavior at school isn't necessarily related to trauma. But, some people say trauma, or some say depression. I’d feel more confident if we had a common understanding.

Another teacher noted that, “I think we’d all feel more confident in working with students if we felt like we knew what we were dealing with, whether it’s trauma or something else. Identifying disorders built my confidence in responding” (Participant Nine). This comment aligned with qualitative data in outcome question one. As aforementioned, Participant Seven illuminated that mental health knowledge and identification aids in the process of choosing the most effective strategies when responding to students’ behaviors and mental health symptoms.

With that in mind, the participants also discussed the need for common district policies regarding student behaviors and symptoms if they cannot effectively be addressed by the classroom teacher. Participant Four disclosed,

> We can do the best that we can in our classroom, but when I think about all of the needs to encompass these children that are struggling with mental illness, the whole system needs a little bit of a rebound to meet their needs effectively. Realistically, we are spread so thin, that we may not be able to identify and reach every student. We haven't been taught how to navigate some of these situations that we've had to encounter.

Along similar lines, Participant Nine noted that "even knowing the person to go talk to if we notice symptoms or have questions would be helpful." Taken together, the participants' comments indicate that district policies that establish clear expectations of staff roles are necessary in helping teachers feel efficacious.

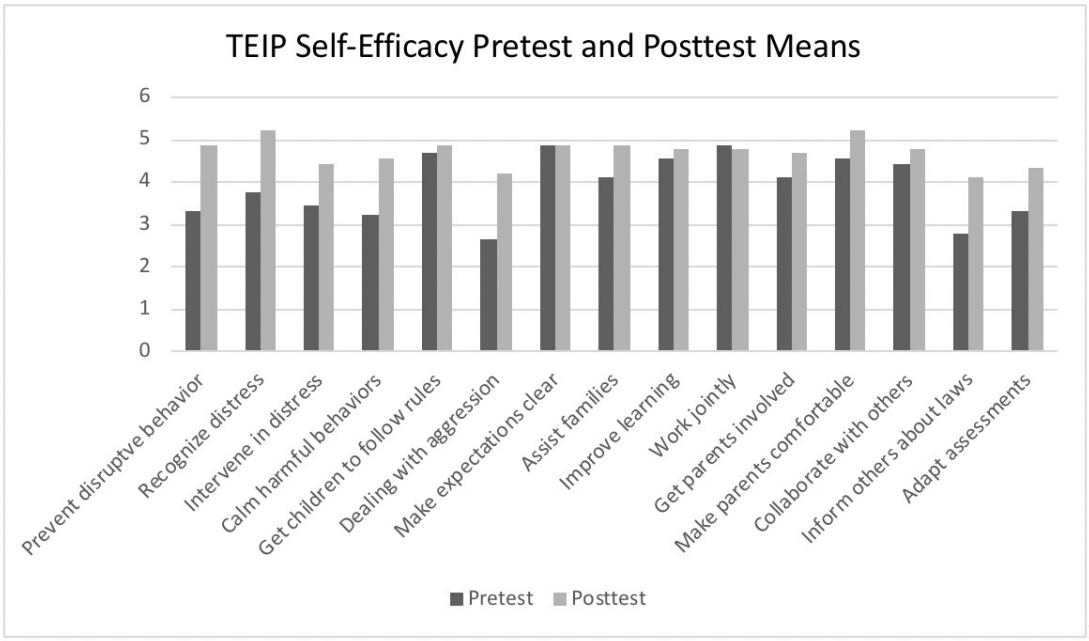
Mixed Methods Findings for Teacher Self-Efficacy

Qualitative data for outcome question two illuminates that the study participants' self-efficacy for working with students with mental health disorders increased between the preintervention and postintervention. To illustrate, Participant Eight noted that the classroom strategies were easy to use in a classroom setting. Specifically, the participant said that, "I am grateful that the strategies are not hard or time consuming. This helped me feel confident in using them." Likewise, Participant Seven stated that developing a greater confidence in identifying disorders helped create greater confidence in implementing supports for students, especially with practical strategies.

Quantitative findings support these findings. The mean averages show growth in the comparison of means of the TEIP pretest and posttests. Figure 6 shows the comparisons of means of the self-efficacy responses of the pretests and posttests.

Figure 6

Teaching Efficacy for Inclusion Practices Pretest and Posttest Means Comparison



Both qualitative and quantitative results support that the PD intervention, which relied on elements of effective PD including modeling, practice, and feedback (e.g., Jensen et al., 2016) were successful in increasing teachers' efficacy in utilizing behavior strategies in responding to mental health symptoms. Quantitative findings for research question two indicate that participants in the intervention group experienced statistically significant improvement ($p<.01$) in their self-efficacy for responding to students with mental health symptoms. The needs assessment in the district showed that teachers had low self-efficacy in responding to aggressive behavior. Teachers in the intervention group experienced significant growth in their TEIP scores

for responding to aggressive behaviors between the pretest (n= 9, M= 2.67, SD= 1.73) and posttest administration (n=9, M= 4.22, SD= .440, p= .023). Qualitative data showed that additional strategy practice and continued support may be needed when school reopens and teachers interact with students in the classroom setting. This key finding aligns with current literature that suggests that job embedded practice is necessary in increasing self-efficacy (Borko, 2004; Learning Forward, 2011).

Discussion of Findings

Population Participation (Process Question One)

Measuring study completeness, or dose, provides information about fidelity (Dusenbury et al., 2003). Understanding dose can aid in establishing a relationship between the amount of content received by participants and study outcomes. Although one participant exited the study after session two, attendance logs indicate high participation during the six PD sessions. The nine teachers who participated in the entire study received 2.5 hours of learning each session for a total of 15 contact hours. Additionally, the teachers participated in classroom practice that took place before school closures in March 2020. Taken together, the teachers received approximately 18 hours of PD. The study's findings show significant increases in teacher mental health knowledge and self-efficacy. Therefore, these findings indicate that participation in professional learning that focuses on symptom recognition and behavioral strategies improves mental health knowledge and self-efficacy.

These results align with current literature about effective PD models (e.g., Borko, 2004, Desimone, 2009, Jensen et al., 2016) that indicate that extended duration increases knowledge and self-efficacy. Intervention data illustrated that elementary teachers developed the ability to recognize students in distress, as well as intervene when a child is experiencing emotional

distress or exhibiting acting out behaviors. An existing study by Jorm (2012) suggests that professional learning for teachers will require extended time for teachers to develop the ability to utilize effective strategies for students exhibiting psychiatric symptoms, as well as administer first aid for those in distress. The study's results also reflect these findings of that study.

Adherence to Professional Development Learning Objectives (Process Question Two)

Assessing program adherence is essential in ensuring the fidelity of implementation (Dusenbury et al., 2003). The current intervention included a program plan, developed to include learning topics, activities, and objectives for each of the six sessions. Adherence to the intervention plan provides connections between the intervention goals and the distal outcomes of the study. The current study reflects adherence to the number, topic, and learning activities of each session. However, the original PD plan included classroom practice between sessions in a classroom context, which was unable to be achieved due to school closures beginning after session two. Because of this, participants reported the need for opportunities for learning to recognize and respond to mental health symptoms in their classrooms, using the strategies taught in the PD sessions.

While this is true, participants did join in learning experiences including modeling and practice with fellow participants, while receiving feedback. Specifically, the teachers participated in role-playing, gallery walks, and games. During the sessions, teachers showed engagement in the session activities by asking questions about the content and receiving and offering feedback during strategy practice. Teachers were also engaged in collaboration with each other in adapting strategies to meet the needs of students at specific grade levels. These learning activities were based on current studies by Desimone (2009) and Tschannen-Moran and McMaster (2009), which illuminate that effective learning includes modeling and practice. The current PD

intervention focused on explicit information and activities to increase teachers' knowledge and identification of mental health disorders and symptoms, as well as classroom strategies to address symptoms. The participants reported that the intervention met the learning objectives and they felt more equipped to teach students with mental health needs, in part because the instructor was able to demonstrate how to recognize and respond to student symptoms in the classroom. An extant study and mental health framework established by Weston and colleagues (2008) indicates that many teacher preparation programs have not afforded teachers to meet the complex demands of providing academic instruction and meeting students' behavioral and mental health needs in elementary classrooms. Therefore, the study not only adds to the body of research regarding teacher PD for student mental health, but also effective teacher PD instruction.

Teacher Mental Health Knowledge (Outcome Evaluation One)

Chapter one presented current literature regarding teacher professional learning and teacher knowledge of student mental health disorders. Current literature indicates that elementary teachers report limited ability to recognize symptoms associated with various disorders (Rothi et al., 2008; Savina et al., 2014; Walter et al., 2006). Along with this, key findings of the needs assessment revealed that teachers did not feel that they could accurately identify disorder symptoms. Specifically, the needs assessment survey showed that 77.2% of respondents either agreed or strongly agreed that they needed more training in being able to recognize various mental health disorder symptoms.

After completing the PD sessions, study participants increased their mental health literacy, by accurately identifying symptoms of childhood mental health disorders. For example, participants increased their understanding that mental health disorders are medical diagnoses. Qualitative and quantitative data show that participants increased their ability to accurately identify symptoms of

mental health disorders, including social phobias, participants were already able to accurately describe symptoms related to bipolar disorder before the PD sessions. Taken together, quantitative and qualitative findings of this study suggest that PD devoted to explicit instruction on specific disorders can increase teachers' ability to recognize and identify mental health symptoms.

Teacher Self-Efficacy (Outcome Evaluation Two)

Results from the needs assessment indicated that teachers in the district lacked self-efficacy in working with students with mental health needs and responding to their mental health symptoms. The needs assessment revealed that the participants had limited self-efficacy in responding to externalized behaviors, including aggressive behaviors. Specifically, on the survey, only one respondent (2.2%) chose strongly agree in feeling confident in dealing with students who are physically aggressive. As would be expected, the current study's pretest reflects similar findings. Findings from the pretest survey indicated that no participants felt efficacious in responding to aggressive behaviors. Contrary, 70% of participants noted that they strongly disagreed (20%), disagreed (40%), or somewhat disagreed (10%) in feeling confident in responding to students' aggressive behaviors.

However, posttest results indicated that teachers had more self-efficacy in working with students with externalized behaviors. To be exact, after the PD sessions, 100% of participants either somewhat agreed (44.4%) or agreed (55.6%) that they were confident in addressing harmful behaviors in the classroom setting. Focus group participants added that they felt confident in using behavior strategies to address emotional distress and calm students in classroom settings. These findings may indicate that participating in the student mental health intervention can increase teacher self-efficacy in responding to students' mental health

symptoms. While school closures reduced the opportunities for the participants to practice strategies in the classroom setting, they engaged in practice with each other and received peer feedback online, via Zoom breakout rooms. Qualitative data did show that classroom practice and ongoing support is needed to continue gaining self-efficacy in addressing students' needs. These findings illustrate the importance and effectiveness of the study's PD program in addressing teachers' self-efficacy through active learning in increasing self-efficacy in responding to elementary students' mental health needs.

Limitations

The key qualitative and quantitative findings of the study indicate increases in participants' knowledge about mental health disorders, as well as increased self-efficacy in recognizing and responding to mental health symptoms. However, the study has several limitations, including small sample size, the necessity of moving to an online platform due to the COVID-19 pandemic, and no comparison group. The study's sample size consisted of ten elementary teachers who work in a suburban public-school district in a Midwest public school district. One participant dropped out of the study after session two due to the pandemic. As such, nine participants received the full intervention dose, thus influencing the generalizability of the research findings. The limited sample size may be a result of the district requirement that the PD sessions occur outside of school hours. Results from the needs assessment study revealed that teachers in the district often do not participate in PD opportunities outside of school hours due to other personal commitments. Likewise, of the nine participants, four of the educators teach in the same elementary school. While non-probability sampling offered convenience in obtaining elementary teachers to participate in the mental health PD intervention, a larger sample size could offer greater insight about teachers' mental health knowledge and self-efficacy more

representative of the elementary teachers in the district. Similarly, a larger sample size enhances the generalizability in findings.

Additionally, the study relies solely on a treatment group. According to Shadish and colleagues (2002), comparing outcomes of the current study to a comparison group increases the external validity of the intervention results. The absence of a comparison group limits the generalizability of the results to other elementary teachers in different contexts.

Finally, in March 2020, mandatory school closures required that the researcher alter the intervention PD sessions from an in-person to web-based format. Effective PD designs include collaboration, active learning, and job-embedded practice (Darling-Hammond & Richardson, 2009; Jensen et al., 2016; Learning Forward, 2011). Although the PD changed to an online format utilizing Zoom, many of the planned PD activities continued as planned. However, the original PD sessions included job-embedded opportunities for the participants to actively engage in practicing the symptom recognition and behavior strategies in the natural contexts of their individual classrooms. School closures prevented this face to face classroom practice. The study participants suggested that the lack of classroom practice influenced their knowledge and self-efficacy in recognizing and responding to students' mental health needs. With that in mind, during the focus group, the participants discussed the need for classroom practice and ongoing support from the researcher or district administration in addressing mental health needs in the classroom environment.

Implications of the Study's Findings

Chapter three delineated current literature in mental health PD, which guided the intervention and theory of treatment. The key results from this dissertation study align with research indicating that PD that includes content-focused and active learning increase teacher self-

efficacy (Tschannen-Moran & McMaster, 2009). Studies (e.g., Darling Hammond et al., 2006) reveal that robust content increases teachers' knowledge and skills, enhancing competence and pedagogical skills to attend to students' needs. The key quantitative and qualitative findings from the intervention illuminate that the content specific sessions increased teachers' ability to recognize and respond to mental health disorders. This section describes the implications for practice and continued research for student mental health interventions for elementary teachers, particularly in distal outcomes of increasing mental health knowledge and self-efficacy.

Implications for Practice

The student mental health PD sessions aimed to improve elementary teachers' knowledge of childhood mental health disorders and symptoms, as well increase self-efficacy in recognizing mental health symptoms and using behavior strategies to address symptoms in classroom settings. The logic model (Figure 3) referenced above shows that the short-term outcome of the intervention includes improving knowledge and increasing self-efficacy when working with students with mental health disorders. Mental health knowledge and self-efficacy in working with students with mental health needs may better prepare teachers to monitor student progress and provide academic and emotional support during the reintegration process (Preyde et al., 2017).

Analysis of the qualitative data illuminated that the participants concluded that the researcher's background as an elementary teacher influenced the program quality. Participants commented that the researcher's classroom experience was beneficial in helping them understand how classroom strategies would fit into classroom environments and dynamics. These findings align with current literature (e.g., Swan Dagen & Bean, 2014) which indicate that teacher leadership models provide collaboration among colleagues by engaging in formal and

informal discourse. Concerning teacher mental health knowledge and self-efficacy, a study by King and colleagues (2014) illuminated that teachers believed that learning from expert teachers allowed for growth in working with students with mental health issues. Likewise, the findings from the current study add to the body of research about effective PD and teacher learning, particularly expert teachers.

Beyond the implications for adherence in the PD intervention, the study findings also offer insight into the benefit of providing teachers with continued support when working with students with mental health needs. Key results from the study show the need for ongoing PD and supports, as well as classroom practice, for teachers to increase knowledge and self-efficacy for recognizing mental health symptoms, as well as utilizing behavioral strategies to respond to student needs in the classroom environment. Existing research, as presented in chapter three, established the importance of ongoing job-embedded learning (Jensen et al., 2016; Learning Forward, 2011). Research specific to teacher mental health training supports the need for ongoing support in understanding student mental health disorders to ask questions and develop strategies as student needs arise (Crosby et al., 2015). While the original PD plan included classroom strategy practice, mandatory school closures reduced that opportunity. Although the results of the present study revealed an increase in teacher knowledge and self-efficacy, qualitative findings suggest the need for practice and feedback when working with students. Such findings suggest that school districts should consider ongoing learning experiences for elementary teachers to promote continued progress in increasing teachers' mental health knowledge and self-efficacy, further encouraging the distal outcomes of increased reintegration successfulness.

Finally, chapter three presented a variety of in-person and online PD options aimed at increasing teachers' mental health knowledge and self-efficacy. These formats included ongoing coaching experiences and online simulations. The original plan for the present intervention included in-person professional learning experiences, which included active learning and practice. However, due to the COVID-19 pandemic, school closures mandated that the PD sessions could no longer be conducted in-person. Therefore, the PD plan adjusted to include synchronous online learning after the second session. Although using Zoom online, the sessions still included elements of effective PD, including active learning and collaboration. With that in mind, this study adds to growing literature that indicates that virtual learning opportunities increases teacher knowledge and self-efficacy.

Implications for Research

Future research about elementary teachers' knowledge and self-efficacy for working with students with mental health needs to happen without the aforementioned limitations. First, the current study relied on a small sample size. Including a larger sample size and control group would provide additional insight about the intervention's effectiveness in increasing knowledge and self-efficacy. As such, providing teachers with the PD sessions, ensuring that the classroom practice to symptom identification and strategy practice occurs, very likely will provide additional insight regarding self-efficacy in recognizing and responding to student needs. Current literature on PD reflects that job-embedded practice influences the development of teacher practices (Darling-Hammond & Richardson, 2009; Jensen et al., 2016; Tschannen-Moran & McMaster, 2009). Considering working with students with mental health issues in classroom settings, research illuminates that classroom training can lead to increases in teachers' helping behaviors, including using restorative practices and making mental health referrals (Crosby,

2015; Fortier et al., 2017). With that in mind, future research must be done to determine if the PD sessions lead to an increase in symptom recognition and strategy utilization in classroom settings, which are both intermediate outcomes shown on the logic model (Figure 3).

Additionally, some participants noted in this study that after the PD sessions their awareness of the complexity of mental health issues increased as a result of the PD intervention. For example, during the focus group interview, two teachers stated that their participation in the PD intervention increased their awareness of mental health issues. For example, Participant Seven commented, "part of me feels slightly overwhelmed because I know more." While the key findings of the study indicate both an increase in mental health knowledge and self-efficacy, other research on self-efficacy shows that in early stages of implementation of new skills, self-efficacy may drop (Guskey, 1986; Tschannen-Moran & McMaster, 2009). The inability to implement strategies in the classroom necessitates that future research examines the sustainability of self-efficacy as teachers apply new knowledge and tools in their classrooms. As key findings show that most participants reported increases and knowledge in efficacy, future research should examine whether these are maintained over time. Similarly, more work must be done to determine if increased knowledge and self-efficacy in working with students with mental health needs increases the successfulness of the reintegration process.

Conclusion

This research study examined the outcomes of nine elementary teachers participating in six monthly PD sessions focusing on student mental health. The purpose of the study was to examine teacher knowledge of mental health disorders, as well as teacher self-efficacy in recognizing and responding to student mental health symptoms. The teachers demonstrated increases in knowledge of mental health disorders, as well as self-efficacy in recognizing and

responding to students' mental health needs. The quantitative evidence helps explain the qualitative findings, suggesting that active learning, including role-playing and strategy practice influenced participants' mental health knowledge and self-efficacy. Current literature corroborates these findings by noting that PD that includes coaching, modeling, and self-reflection increases teacher self-efficacy (Borko, 2004; Desimone, 2009).

Likewise, key findings indicate that continued support and education opportunities may benefit teachers in utilizing their new learning in the classroom setting. Due to required school closures, the PD format eliminated a job-embedded practice component. Job-embedded PD allows teachers to apply new learning and engage in collaboration, which promotes sustained implementation (Learning Forward, 2011). Qualitative findings illuminated the participants' perceptions of a continued need to practice newly learned skills in their classrooms.

Going forward, the researcher, also an employee in the intervention district, will provide ongoing guidance and job-embedded learning for study participants by making classroom observations, modeling, co-teaching and providing actionable feedback on the participants' utilization of classroom strategies. The decision for the researcher to continue to provide district supported ongoing teacher support comes from current literature, which shows that working with expert teachers increases shared responsibility and collaboration, leading to teacher changes in practice and student outcomes (Jensen et al., 2016; Learning Forward, 2011; Swan-Dagen & Bean, 2013).

The results and key findings of this research study indicate that providing elementary teachers with professional learning based on effective PD elements, such as active learning and sustained duration, positively affect teachers' knowledge and self-efficacy related to student mental health. The study participants showed increased knowledge of mental health disorder symptoms, as well

as self-efficacy in recognizing mental health disorders. Similarly, the key findings illuminate increased teacher self-efficacy in working with students exhibiting mental health symptoms. Therefore, the PD sessions should be considered as an approach for teachers working with elementary students with mental health disorders. Similarly, this PD intervention should be considered in assisting school to reach short-term outcomes related to the school reintegration process following elementary students' psychiatric hospitalization.

Qualitative data revealed that participants found the researcher's teaching experience beneficial in increasing their knowledge and self-efficacy in working with students with mental health disorders. Participants believed that the researcher's understanding of classroom dynamics led to practical and easy to use strategies being taught throughout the PD sessions. Current literature illuminates that teachers as leaders in mentoring and PD facilitators increases teachers' performance and use of new instructional strategies (Clarke & Hollingsworth; Desimone & Garet, 2015; Swan Dagen & Bean, 2014). Future research should further examine the effectiveness in using teacher experts for mental health PD.

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Appendix A

Teaching Students with Mental Health Needs Questionnaire

The purpose of this survey is to understand teacher beliefs, teacher efficacy, and professional development needs in dealing with student mental health needs in the classroom.

This survey is being conducted by Jennifer Timmer, Lincoln Elementary teacher, and Johns Hopkins University doctoral student. The data from the survey may or will become part of the student researcher's dissertation study. No identifiable information will be collected from the survey.

Your participation in this survey is completely voluntary. You may choose whether to participate or not. If you decide not to participate, there are no penalties. If you choose to participate, you can skip any question or stop your participation at any time, without penalty. If you choose to participate, please complete by June 8, 2018.

Thanks for your consideration!

Background Information

These questions are about you, your education, and the time you have spent teaching. Check the boxes to answer.

1. What is your gender?
   - ☐ Female
   - ☐ Male
   - ☐ Prefer not to answer

2. What is your current teaching employment status?
   - ☐ Full-time
   - ☐ Half -time
   - ☐ Less than half time

3. How many years of service have you earned as a certified teacher?
   - ☐ 0-4 years

- 5-9 years
- 10-14 years
- 15-19 years
- 20-24 years
- 25-29 years
- 30 or more years

4. What is your highest level of education attained?
   - Bachelor's degree
   - Master's Degree
   - Professional Degree or Certification (e.g. Ed.S or S.Ed)
   - Doctoral Degree

5. What subjects do you teach? Check all that apply.
   - K-2 General Education
   - 3-5 General Education
   - Spanish Immersion
   - Special Education or Speech Pathologist
   - Specialist
   - Reading or Math Intervention

Beliefs and Attitudes

These questions are about beliefs and attitudes toward working with students with mental health disorders. After reading each statement, please circle the number to the right that best reflects your opinion.

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
6. I believe that an inclusive school is one that promotes academic or social progression of all students regardless of their ability.	1	2	3	4	5	6
7. I believe that students with mental health disorders should be taught in specialty schools.	1	2	3	4	5	6
8. I believe that inclusion facilitates socially appropriate behavior amongst all students.	1	2	3	4	5	6
9. I believe that students with mental health disorders should be in a self-contained classroom because it is too expensive to modify the physical	1	2	3	4	5	6

10. I believe that students with mental health disorders should be in specialty schools so that they do not experience rejection in regular schools.	1	2	3	4	5	6
11. I get frustrated when I have difficulty communicating and interacting with students with mental health disorders.	1	2	3	4	5	6
12. I get upset when students with mental health disorders cannot keep up with the day-to-day curriculum in my classroom.	1	2	3	4	5	6
13. I get irritated when I am unable to understand the needs of students with a mental health disorder.	1	2	3	4	5	6
14. I am uncomfortable including students with mental health disorders in a regular classroom with other students without a disability.	1	2	3	4	5	6
15. I am disconcerted that students with a mental health disorder are included in the regular classroom, regardless of the severity.	1	2	3	4	5	6
16. I get frustrated when I have to adapt the curriculum to meet the individual needs of all students.	1	2	3	4	5	6
17. I am willing to encourage students with mental health disorders to participate in all social activities in the regular classroom.	1	2	3	4	5	6
18. I am willing to adapt the curriculum to meet the individual needs of all students regardless of their ability.	1	2	3	4	5	6
19. I am willing to include students with severe mental health needs in the regular classroom with the necessary	1	2	3	4	5	6

20. I am willing to modify the physical environment (e.g., time out spaces) to include students with a mental health disorder in the regular classroom.	1	2	3	4	5	6
21. I am willing to adapt my communication techniques to ensure that all students with an emotional and/or behavioral disorder can be successfully included in the regular classroom.	1	2	3	4	5	6
22. I am willing to adapt the assessment and service referral of individual students in order for inclusive education to take place.	1	2	3	4	5	6

Self-Efficacy

These questions ask about your efficacy and confidence in teaching students with mental health disorders. After reading each statement, please circle the number to the right that best reflects your opinion.

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
23 I am confident in my ability to prevent disruptive behavior in the classroom before it occurs.	1	2	3	4	5	6
24.I can recognize when a student is in emotional distress.	1	2	3	4	5	6
25. I can intervene when a student is in emotional distress	1	2	3	4	5	6
26.I am able to calm a student who is exhibiting acting out or harmful behaviors.	1	2	3	4	5	6
27. I am able to get children to follow the rules.	1	2	3	4	5	6

28.I am confident when dealing with children who are physically aggressive.	1	2	3	4	5	6
29.I can make my expectations clear about student behavior.	1	2	3	4	5	6
30.I can assist families in helping their children do well in school.	1	2	3	4	5	6
31.I can improve the learning of a student who is failing.	1	2	3	4	5	6
32.I am able to work jointly with other professionals and staff (e.g., aides, other teachers) to teach students with mental health disorders in the classroom.	1	2	3	4	5	6
33.I am confident in my ability to get parents involved in school activities of their children with mental health disorders.	1	2	3	4	5	6
34.I can make parents feel comfortable coming to school.	1	2	3	4	5	6
35.I can collaborate with other professionals (e.g., itinerant teachers or speech pathologists) in designing educational plans for students with mental health disorders.	1	2	3	4	5	6

36.I am confident in informing others who know little about laws and policies relating to the inclusion of students with mental health disorders.	1	2	3	4	5	6
37. I am confident in adapting school-wide or state-wide assessments so that students with mental health disorders can be assessed.	1	2	3	4	5	6

Professional Development

These questions are about teacher training and professional development in working with students with mental health disorders. After reading each statement, please circle the answer to the right that best reflects your experience.

	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree	N/A
37. Courses or workshops	1	2	3	4	5	6	7
38.Conferences	1	2	3	4	5	6	7
39. Degree or qualification	1	2	3	4	5	6	7
40.Visiting other schools or classrooms	1	2	3	4	5	6	7
41. Participating in a learning community (PLC)	1	2	3	4	5	6	7
42. Mentoring or coaching other teachers	1	2	3	4	5	6	7
43. Reading professional journals	1	2	3	4	5	6	7

44. Engaging in informal discussions with other teachers	1	2	3	4	5	6	7

During the last 18 months, the following professional development opportunities about working with students with mental health needs positively impacted how I work with them in the classroom:

45. Approximately how many days of professional development regarding student mental health did you participate in during the past 18 months? _____

46. Approximately how many of these professional development opportunities took place within regularly scheduled school hours?_____

I need more information on the following areas to improve my ability to work with students with mental health needs:

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
47. Instructional strategies (i.e., how to meet academic needs of struggling students).	1	2	3	4	5	6
48. Assessing and referring students for mental health services.	1	2	3	4	5	6
49. Classroom management (i.e., how to manage acting out behaviors).	1	2	3	4	5	6
50. Understanding symptoms of different mental health disorders.	1	2	3	4	5	6
51. Understanding how different disorders affect the brain.	1	2	3	4	5	6
52. Understanding how different disorders affect learning/cognition.	1	2	3	4	5	6

Thank you for completing the survey.

Appendix B

Needs Assessment Focus Group Questions

- Talk about how elementary students transition into school and classrooms after psychiatric hospitalization.

- I'd like to talk about the roles different stakeholders play during the transition process, and hear your opinions about these. First, let's discuss the teachers' role. What role, if any, do you believe you play during reintegration process?
    - Follow with principal and parent roles.
    - Follow-up: how would you change these roles in any way to make the reintegration process more successful?

- What are, or might be, barriers to students' success when transitioning into school?
    - Follow up: are there service barriers that inhibit student success?

- How does the school environment impact the transition process? This could be how welcoming classrooms or how classroom management strategies are implemented.
    - Follow up: how do you think the school behavior policies impact transition?

- What, if any, information do you believe teachers should be provided about a student's mental health disorder before he/she transitions back into school?
    - Follow-up: how would that information help teachers prepare for the student's return?

- Discuss the kind of support you would like to have during this process.
    - Follow up: are there ancillary staffing supports you feel are necessary?
    - Follow up: are there training supports you feel are necessary?

Appendix C

Professional Development Sessions

Program Action Plan

The main goal of the professional learning program is to facilitate and support teachers' ability to identify and recognize childhood mental health disorders, as well as use strategies to respond to mental health symptoms in classroom settings. Therefore, the goal of the professional learning program is to increase teacher knowledge of mental health symptoms and increase self-efficacy recognizing and responding to student mental health needs.

The primary curriculum influencing the professional learning program is The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success (Wolpow, Johnson, Hertel, & Kincaid, 2016). The curriculum is designed to help elementary teachers recognize mental health symptoms, as well as implement classroom and behavioral strategies. Specifically, the curriculum provides teachers with three domains for increasing mental health knowledge, teaching emotional and behavioral self-regulation, and promoting student agency and social skills.

The professional learning program intervention focuses on developing elementary teachers' knowledge of mental health and self-efficacy in working with students with mental health problems through hands-on and collaborative sessions. All certified elementary teachers within the district may participate in six 2.5-hour monthly sessions.

Program Overview

Current literature suggests that elementary teachers need more training in recognizing mental health disorder symptoms, as well as developing strategies to address symptoms in classroom settings (Alisic, 2012; Clemens, Welfare, & Williams, 2011; Reinke, Stormont,

Herman, Puri, & Goel, 2011). Elementary teachers report having limited knowledge and self-efficacy when working with students with mental health disorders (Buell, Hallam, Gamal-Mccormick, & Scheer, 1999; Graham, Phelps, Maddison, and Fitzgerald, 2011). Specifically, teachers posit that they are unsure how to address externalized behaviors in classroom settings (Reinke et al, 2011; Walter, Gouze, & Lim, 2006).

This program is based on a modified version of The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success curriculum (Wolpow, Johnson, Hertel, & Kincaid, 2016). The curriculum provides information about psychiatric disorders within a compassionate instructional and discipline framework. Specifically, the curriculum offers information based on six principles. Principle one notes that teachers should always empower, never disempower. Principle two posits that teachers should provide unconditional positive regard toward students, while principle three maintains that high expectations should be held for all students. Furthermore, principle four suggests that teachers should check their assumptions about students. Principle five focuses on teachers obtaining the role of a relationship coach. Finally, principle six notes that teachers should provide guided opportunities for classroom participation. With this framework in mind, the curriculum ascertains that classroom strategies are based on three domains: safety, connection, and assurance; emotional and behavioral regulation; personal agency and social skills. The program also utilizes mental health disorder information and strategies from the Be You student mental health program created by the Australian government.

Information about mental health disorders symptoms and classroom strategies will be presented in a hands-on and collaborative format. Current literature postulates that active, content focused, context-embedded professional learning formats are elements of effective professional learning

(Borko, 2004; Darling-Hammond & Richardson, 2009; Desimone, 2009; Jensen, Sonnemann, Roberts-Hull, & Hunter, 2016; Tschannen-Moran and McMaster, 2009). The current program relies on these elements of effective professional learning, incorporating teacher collaboration, classroom practice, and modeling.

Professional Learning Sessions

The teacher participants will attend six professional learning sessions throughout the program. Each session last approximately 2.5 hours. Additionally, teachers will practice using skills and strategies from the professional learning sessions in their classrooms; this provides an opportunity for classroom-embedded practice. Teachers are encouraged to have other teachers observe strategy implementation in their classrooms for feedback. Teachers will be given ample time during the following session to reflect on their experiences, as well as collaborate about necessary modifications and adaptations for continued use in their classrooms. Teachers will be advised about the importance of not sharing specific student information during the sessions. Each session will be comprised of many components including collaborative groups, learning about mental health disorder, and learning about classroom strategies. As teachers practice strategies in the session, they will receive feedback. Teachers will also have a brief period for reflection and questions and answers at the end of each session.

Session 1: Program introduction and depressive disorders

Teachers will be able to explain the purpose and expectations of the professional learning program. Additionally, teachers will be able to explain their role in understanding, recognizing, and responding to student mental health symptoms in school and classroom settings. Lastly, teachers will be able to define and recognize depressive disorders.

1. Introduction
    a. Ice-breaker activity to build relationships and collaboration

    b. Introduce the format and topics of the program related to student mental health
    c. Explain expectations of the program (i.e., not discussing student information)
2. Discuss importance of teachers understanding student mental health disorders
    a. Show TedTalk video related to importance of teachers' knowledge of mental health in classroom settings
3. Discuss basic brain structure to discuss brain structure as it pertains to learning and mental health disorders.
    a. Create brain hats to show basic structure and overview of functioning
4. Identify depressive disorders
    a. Define and identify symptoms of depressive disorders
        i. Read excerpts from chapter books to "see" symptoms
        ii. Identify disorders through vignettes to practice recognizing symptoms
        iii. Role play symptoms with partners to practice recognizing symptoms and responding
5. Classroom strategies
    a. Creating calm zones in the classroom: teach how to take a break to reduce overwhelming feelings
    b. Using vocabulary of emotions through read alouds: teach students how to recognize and name feelings in the classroom
6. Wrap-up reflection
    a. Discuss as a group learning that was new or unexpected
    b. Present classroom embedded practice that is expected before next session
7. Classroom-embedded practice
    a. Read article from Be You
    b. Complete shape-up reflection sheet
8. Exit tickets
    a. To what extent did you learn what you expected to learn in today's session?
    b. How did your knowledge of student mental health disorders change today?
        i. Fill out with unique identifier code and turn in before leaving

Session 2: Anxiety and Mood Disorders

Teachers will be able to identify symptoms related to anxiety and mood disorders. Teachers will identify strategies that may be beneficial with students exhibiting symptoms. Teachers will also compare symptoms of depressive disorders with anxiety and mood disorders.

1. Collaboration
    a. Discuss article and reactions to the information about childhood depression
    b. Share item. What does it represent? What feelings does that evoke?
2. Identify anxiety and mood disorders
    a. Define and identify symptoms of related disorders
    b. Compare disorders and participate in a "gallery walk", an activity where teachers will discuss posters of symptoms throughout the room.
    c. Watch disorder videos (NAMI.com) in small groups to recognize symptoms

    d. Begin creating symptoms flipbook to have a visual for teachers to use in their classrooms for recognizing disorder symptoms
3. Classroom strategies
    a. Inner critic vs. Inner coach strategy to teach how to recognize and change negative self-talk
    b. Silly Street game: teach confidence building and empathy
    c. Feelings lock-box: teach students how to recognize and express emotions
4. Wrap-up reflection
    a. Discuss session content
    b. Present classroom-embedded practice
5. Classroom-embedded practice
    a. Play the Silly Street game with students
        i. How do students respond? What are students' thoughts or reactions?
6. Exit tickets
    a. To what extent did you learn what you expected to learn in today's session?
    b. How are you better prepared to recognize mental health symptoms in your classroom after today's session?
    c. How confident do you feel in determining the difference between different mental health disorders?
        i. Fill out with unique identifier code and turn in before leaving

Session 3: Post-Traumatic Stress Disorder

Teachers will be able to identify symptoms related to PTSD and risk factors related to the disorder. Teachers will identify strategies that may be beneficial with students exhibiting symptoms.

1. Collaboration
    a. Discuss experience with game in the classroom with students. What worked? What did not work? Suggestions?
2. Identify PTSD
    a. Define and identify symptoms of disorder
    b. Continue adding to symptoms flipbook to have a visual for teachers to use in their classrooms for recognizing disorder symptoms
    c. Trigger identification activity
3. Classroom strategies
    a. Grounding strategies: teach how to stay in the present moment, rather than becoming overwhelmed or distracted by intense emotions
        i. Grounding activities classroom chart
    b. Size of the problem strategy: teach that reactions (behaviors) should match the problem
4. Wrap-up reflection
    a. Discuss session content
    b. Present classroom-embedded practice

5. Classroom-embedded practice
    a. Practice grounding activities with students
        i. How do students respond? What are students' thoughts or reactions?
6. Exit tickets
    a. To what extent did you learn what you expected to learn in today's session?
    b. What was the most important thing you learned from today's session?
        i. Fill out with unique identifier code and turn in before leaving

Session 4: Conduct Disorder

Teachers will be able to identify symptoms related to conduct disorders. Teachers will identify strategies that may be beneficial with students exhibiting symptoms. Teachers will also compare symptoms of depressive disorders with anxiety and mood disorders.

1. Collaboration
    a. Discuss grounding activities. What worked well? What did not? What would you change? What else do you need?
    b. Step to the line activity to practice identifying previous disorder symptoms
2. Identify conduct disorder
    a. Define disorders (define, identify symptoms)
    b. I have, who has activity for symptom recognition
    c. Case-study activity to recognize symptoms in a context and apply strategies
    c. Continue creating symptoms flipbook to have a visual for teachers to use in their classrooms for recognizing disorder symptoms
3. Classroom strategies
    a. Deep breathing exercises
        i. Calm down cupcake strategy to teach calming strategies (vs. fight or flight)
        ii. Lazy 8 strategy to teach calming strategies (vs. fight or flight)
        iii. Giraffe Talk strategy to teach nonviolent, nonaggressive communication skills
            1. Start creating strategy flipbooks
4. Wrap-up reflection
    a. Discuss session content
    b. Present classroom-embedded practice
5. Classroom-embedded practice
    a. Practice one strategy with students in the classroom
        i. How to students respond? What are students' thoughts or reactions?
    b. Brainstorm questions you'd like to ask parents about student mental health
6. Exit tickets
    a. How are you better prepared to respond to mental health symptoms in your classroom after today's session?
    b. How confident do you feel in using the strategies in your classroom?
        i. Fill out with unique identifier code and turn in before leaving

Session 5: Attention Deficit/Hyperactivity Disorder

Teachers will be able to identify symptoms related to ADHD. Teachers will identify strategies that may be beneficial with students exhibiting symptoms. Teachers will also engage with parents of children with mental health disorders to gain a deeper understanding of family perspectives.

1. Collaboration
    a. Discuss the experiences and reactions to the strategy use in the classroom environment.
    b. Three-minute teaching challenge to practice strategies
2. Identify ADHD
    a. Define and identify symptoms of disorders
        i. ADHD student video
    b. Continue creating symptoms flipbook
3. Classroom strategies
    a. Tactile strategies to address fidgeting and active engagement
    b. Visual reminders to teach students how to limit distractions, stay organized
    c. Brain break activities to teach how to redirect and refocus
4. Parent panel of children with mental health disorders
    a. Panel will consist of parents of children with various mental health disorders
    b. Panel will not consist of parents of children from the school district
    c. Parents will explain the symptoms related to their child's diagnosis, how it affects daily life, how it affects school experience
    d. Parents will offer time for teacher question and answer session
5. Wrap-up reflection
    a. Discuss session content
        i. Concentric circles activity to discuss content
    b. Present classroom-embedded practice
6. Classroom-embedded practice
    a. Discuss with a colleague how to have effective conversations with parents. What will you change in your classroom practices? Keep the same?
7. Exit tickets
    a. How are you better prepared to respond to mental health symptoms in your classroom after today's session?
    b. In what ways did your perceptions of student mental health change as a result of engaging with parents?
    c. How confident do you feel in using the strategies in your classroom?
        i. Fill out with unique identifier code and turn in before leaving

Session 6: Obsessive Compulsive Disorder and Conclusion

Teachers will be able to identify symptoms related to OCD. Teachers will identify strategies that may be beneficial with students exhibiting symptoms. Teachers will present the information they have learned throughout the sessions.

1. Collaboration
    a. Discuss impressions of parent panel experience
2. Identify OCD
    a. Define and identify symptoms of disorder
3. Classroom strategies
    a. calming corner for stress reduction and
    b. preferential seating to minimize distractions and stress
    c. breaking work into chunks to make work look less overwhelming
4. Learning showcase
    a. Teachers share learning with administrators
        i. How changed their knowledge and ways to address student needs
        ii. Showcase games, flipbooks, etc.
5. Wrap-up reflection
    a. Discuss session content
        i. How has learning helped in the classroom setting?
6. Exit tickets
    a. How confident do you feel in recognizing and responding to student mental health needs?
    b. Has your confidence changed during the sessions? In what way?
    c. What was the most important thing you learned through the sessions?
        i. Fill out with unique identifier code and turn in before leaving

Classroom-embedded Practice

As noted above, teachers are expected to apply the skills and strategies taught in the professional learning sessions in their school and classroom settings. This application will take place between the professional learning sessions. Teachers are expected to practice and apply these strategies in their own settings and collaborate with colleagues during the subsequent session about appropriate changes, adaptations, etc. that may be necessary for their students. Additionally, teachers may also hold discussions and observations for feedback, as needed (and as desired).

Appendix D

Post-Intervention Focus Group Questions

As a student researcher, Jen Timmer, is working with Dr. Marcia Davis through Johns Hopkins University to collect information that will help evaluate a professional learning program to increase elementary teachers' knowledge and self-efficacy in working with students with mental health needs. The research project will also provide the researcher with information to support teachers in meeting the needs of students in your classrooms. Your participation in the focus group is voluntary. You are free to omit any question that you do not wish to answer, but your responses will be valuable in learning about your experiences in working with students with mental health needs. The focus group responses will be recorded and transcribed.

1. I'd like to talk about your experience in the professional development sessions. What information or activity did you benefit from the most during the professional learning sessions?

2. I am wondering how the sessions influenced your knowledge and efficacy in meeting student mental health needs. What role, if any, do you believe the sessions played in influencing your knowledge? Efficacy?

3. To what extent do you feel that the sessions met the learning objectives presented?
    a. Is there information that you wish would have been covered during the professional learning sessions?

4. Talk about your ability to recognize student mental health needs.
    a. Has your ability to recognize student symptoms changed because of the sessions?
    b. What do you know now that you did not know before about student mental health?

5. How confident do you feel in recognizing student mental health needs in the classroom? What about responding to these needs?

6. How confident do you feel using the strategies from the PD sessions?

7. What are, or might be, information, skills, or strategies that you still need to feel confident in working with students with mental health needs?

8. Is there something else you would like to mention that we have not talked about?

Appendix E

Mental Health for Elementary Teachers Survey

As a student researcher, Jen Timmer, is working with Dr. Marcia Davis through Johns Hopkins University to collect information that will help evaluate elementary teachers' knowledge and self-efficacy in working with students with mental health needs. The research project will also provide the researcher with information to support teachers in meeting the needs of students in your classrooms.

Your participation in the survey is voluntary. You are free to omit any question that you do not wish to answer, but your responses will be valuable in learning about your experiences in working with students with mental health needs. Your responses are completely confidential and will only be used in summary averages over a larger sample of teachers.

Enter your unique identification code.

These questions are about you, your education, and the time you have spent teaching. Check the boxes to answer.

1. What is your gender?
   - ☐ Female
   - ☐ Male
   - ☐ Other
   - ☐ Prefer not to answer

2. What is your current teaching employment status?
   - ☐ Full-time
   - ☐ Half -time
   - ☐ Less than half time

3. How many years of service have you earned as a certified teacher?
   - ☐ 0-4 years
   - ☐ 5-9 years
   - ☐ 10-14 years

- 15-19 years
- 20-24 years
- 25-29 years
- 30 or more years

4. What is your highest level of education attained?
   - Bachelor's degree
   - Master's Degree
   - Professional Degree or Certification (e.g. Ed.S or S.Ed)
   - Doctoral Degree

5. What subjects do you teach? Check all that apply.
   - K-2 General Education
   - 3-5 General Education
   - Spanish Immersion
   - Special Education or Speech Pathologist
   - Specialist
   - Reading or Math Intervention

These questions ask about your efficacy and confidence in teaching students with mental health disorders. After reading each statement, please circle the number to the right that best reflects your opinion.

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
6. I am confident in my ability to prevent disruptive behavior in the classroom before it occurs.	1	2	3	4	5	6
7.I can recognize when a student is in emotional distress.	1	2	3	4	5	6
8. I can intervene when a student is in emotional distress	1	2	3	4	5	6
9.I am able to calm a student who is exhibiting acting out or harmful behaviors.	1	2	3	4	5	6

10. I am able to get children to follow the rules.	1	2	3	4	5	6
11.I am confident when dealing with children who are physically aggressive.	1	2	3	4	5	6
12.I can make my expectations clear about student behavior.	1	2	3	4	5	6
13.I can assist families in helping their children do well in school.	1	2	3	4	5	6
14.I can improve the learning of a student who is failing.	1	2	3	4	5	6
15.I am able to work jointly with other professionals and staff (e.g., aides, other teachers) to teach students with mental health disorders in the classroom.	1	2	3	4	5	6
16.I am confident in my ability to get parents involved in school activities of their children with mental health disorders.	1	2	3	4	5	6
17.I can make parents feel comfortable coming to school.	1	2	3	4	5	6

18.I can collaborate with other professionals (e.g., itinerant teachers or speech pathologists) in designing educational plans for students with mental health disorders.	1	2	3	4	5	6
19.I am confident in informing others who know little about laws and policies relating to the inclusion of students with mental health disorders.	1	2	3	4	5	6
20. I am confident in adapting school-wide or state-wide assessments so that students with mental health disorders can be assessed.	1	2	3	4	5	6

The purpose of these questions is to gain an understanding of your knowledge of various aspects concerning mental health. When responding, we are interested in your degree of knowledge. After reading the question, choose the number to the right that best reflects your experience.

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
21. If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or in performance (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and would act in a way that was humiliating or feel embarrassed, they have social phobia.	1	2	3	4	5	6
22. If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry, and had physical symptoms such as having tense muscles or fatigue,	1	2	3	4	5	6

they likely have Generalized Anxiety Disorder.						
23. If someone experienced a low mood for two weeks, had a loss of pleasure or interest in their normal activities, and experienced changes in their appetite and sleep, they likely have a major depressive syndrome.	1	2	3	4	5	6
24. Personality disorders are a form of mental illness.	1	2	3	4	5	6
25. Dysthymia (Pervasive Depressive Disorder) is an actual disorder.	1	2	3	4	5	6
26. The diagnosis of agoraphobia includes anxiety about situations where escape may be difficult or embarrassing.	1	2	3	4	5	6
27. Bipolar disorder includes experiencing periods of elevated and depressed moods.	1	2	3	4	5	6
28. The diagnosis of a drug dependence includes physical and psychological intolerance of the drug.	1	2	3	4	5	6
29. In general, girls are MORE likely to experience a mental illness of any kind compared to boys.	1	2	3	4	5	6
30. In general, boys are MORE likely to experience an anxiety disorder than girls.	1	2	3	4	5	6
31. It is important for someone to improve their quality of sleep if they were having difficulty managing their emotions (e.g., become very anxious or depressed).	1	2	3	4	5	6
32. It is important for someone to avoid all activities or situations that made them feel anxious if they were having difficulty managing their emotions.	1	2	3	4	5	6

The purpose of these questions is to understand your help-seeking behaviors to help students with mental health problems. After reading the question, please choose the number to the right that best reflects your experience.

	Strongly disagree	**Disagree**	**Somewhat disagree**	**Somewhat agree**	**Agree**	**Strongly agree**
33. I am confident I know where to seek information about student mental health.	1	2	3	4	5	6
34. I am confident in using the internet or calling to find information about student mental health.	1	2	3	4	5	6
35. I am confident in talking to parents about student mental health.	1	2	3	4	5	6
36. I have access to school resources that I can use to find information about student mental health.	1	2	3	4	5	6
37. Students with mental illness can snap out of it when they want.	1	2	3	4	5	6
38. Mental illness is a sign of weakness.	1	2	3	4	5	6
39. Mental disorders are not real diagnoses.	1	2	3	4	5	6
40. Student with mental illness are dangerous.	1	2	3	4	5	6
41. It is best to keep "normal" students away from students with mental illness so they don't develop the symptoms or behaviors.	1	2	3	4	5	6
42. If I had a mental illness I would not tell anyone.	1	2	3	4	5	6
43. Seeing a mental health professional means that parents and students are not strong enough to manage their difficulties.	1	2	3	4	5	6

44. If I had a student with mental illness, I would not seek help from school mental health providers (e.g., social worker, psychologist, etc.).	1	2	3	4	5	6

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